

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom  
Ronald Reagan Building  
International Trade Center  
1300 Pennsylvania Avenue, NW  
Washington, D.C. 20004

Thursday, January 16, 2020  
9:04 a.m.

COMMISSIONERS PRESENT:

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1 recommendations.

2           In 2019, among more than 61 million Medicare  
3 beneficiaries, 74 percent were enrolled in Part D plans.  
4 Just over 2 percent got drug benefits through the retiree  
5 drug subsidy, in which employers provided primary drug  
6 benefits to their retirees in return for Medicare  
7 subsidies. The remaining 23.6 percent was divided fairly  
8 equally between beneficiaries who had other sources of drug  
9 coverage as generous as Part D and beneficiaries with no  
10 drug coverage or less generous coverage.

11           Medicare program spending for Part D was more  
12 than \$83 billion in 2018, predominantly for payments to  
13 private plans, and \$800 million for the RDS. Part D makes  
14 up about 13 percent of total Medicare spending.

15           In addition, Part D enrollees directly paid over  
16 \$14 billion in premiums for basic benefits, as well as  
17 additional amounts for cost sharing and supplemental  
18 coverage.

19           More than eight in ten enrollees say they are  
20 satisfied with the program and with their plans.

21           Since the start of Part D, enrollment has grown  
22 at about 5 percent per year overall, but with faster growth

1 in Medicare Advantage drug plans than stand-alone PDPs. In  
2 2019, 44 percent of enrollees were in MA-PDs and 56 percent  
3 in PDPs. Twenty-eight percent of all Part D enrollees  
4 receive the low-income subsidy, which provides extra help  
5 with premiums and cost sharing, which is down from 39  
6 percent in 2007. Since 2010, many employers have moved  
7 their retirees out of the RDS and into Part D plans set up  
8 for them. Today about 16 percent of all Part D enrollees  
9 are in employer group plans.

10           The average Part D premium across both PDPs and  
11 MA-PDs decreased slightly in 2019 to \$29 per month.  
12 Average premiums have remained at around \$30 per month  
13 since 2010 despite big growth in catastrophic benefits.  
14 However, there's wide variation in Part D premiums across  
15 individual plans.

16           Plan sponsors offered more options for 2020, with  
17 higher growth in MA-PDs relative to PDPs and in special  
18 needs plans with drug coverage. There are also 13 percent  
19 more PDPs that bid low enough to make them premium-free to  
20 low-income subsidy enrollees.

21           This table compares Part D spending at the first  
22 full year of the program, 2007, with 2017 and 2018.

1           The direct subsidy is a monthly capitated  
2 payment, adjusted for risk, that Medicare pays plans for  
3 each enrollee. Reinsurance is a cost-based payment because  
4 Medicare reimburses plans 80 percent of the actual cost of  
5 prescriptions filled in the catastrophic phase of the  
6 benefit. Those two subsidies combined are designed to  
7 cover about 75 percent of the cost of basic benefits for  
8 all enrollees. Medicare's low-income subsidy payments to  
9 plans cover the extra help that LIS enrollees receive for  
10 cost sharing and premiums. You can see that total Medicare  
11 program spending for Part D increased from \$80 billion in  
12 2017 to \$83 billion in 2018.

13           What we've been concerned about is that  
14 Medicare's payments to plans based on cost have grown while  
15 those based on risk have declined. Reinsurance has grown  
16 by an annual average of 16 percent since 2007, totaling  
17 \$40.9 billion in 2018. Reimbursement to plans for low-  
18 income cost sharing makes up the vast majority of the \$28.6  
19 billion of LIS spending, and LIS spending has increased by  
20 5 percent annually. With low-income cost sharing, plans  
21 are paid their actual costs. Meanwhile, between 2007 and  
22 2018, the direct subsidy, which is risk-based, decreased by

1 nearly 3 percent. Risk-based payments generally provide  
2 sponsors with stronger incentives to manage benefits.

3           Part D uses a market-oriented approach in the  
4 sense that private plans compete for enrollees based on the  
5 drugs they cover, cost sharing, pharmacy networks, and  
6 premiums. The original intent was to give plan sponsors  
7 strong financial incentives to manage benefits by having  
8 them bear insurance risk. For plans to come out ahead,  
9 their revenues from premiums and capitated payments need to  
10 be higher than benefit spending and administrative costs.

11           Under Part D, plan sponsors use PBM tools such as  
12 formularies with tiered cost sharing, rebates from  
13 manufacturers, and negotiated payment rates with  
14 pharmacies. To help ensure appropriate access, CMS places  
15 restrictions on some of these tools that are tighter than  
16 what plans can use for their commercial clients. Shinobu  
17 will review some of these in a minute.

18           Part D includes Medicare subsidies, risk-sharing,  
19 and a late enrollment penalty. At the start of the  
20 program, those features were intended to encourage market  
21 entry by plan sponsors and broad enrollment among  
22 beneficiaries. But since then, many things have changed.

1           Early on, plans were successful at switching  
2 enrollees to generics for many widely prevalent conditions  
3 like high cholesterol.

4           By 2010, manufacturers had shifted focus to  
5 specialty drugs that treat conditions with smaller patient  
6 populations, like rheumatoid arthritis and cancer. These  
7 newer therapies are often very expensive, and their list  
8 prices grew rapidly.

9           Part D's benefit design changed. The Affordable  
10 Care Act called for phasing out the coverage gap for  
11 beneficiaries who don't receive the low-income subsidy. To  
12 help finance the more generous benefit, manufacturers of  
13 brand-name drugs were required to discount their products  
14 in the coverage gap. However, the discount makes the  
15 relative price of brands artificially cheaper to plans and  
16 enrollees, and this is one of the key reasons Part D needs  
17 to be restructured.

18           There has been rapid growth in Medicare's cost-  
19 based payments to plans -- that is, reinsurance for 80  
20 percent of catastrophic benefits and low-income cost  
21 sharing. Most enrollees who reach the catastrophic phase  
22 receive the low-income subsidy, so growth in low-income



1 cost sharing interacts with growth in reinsurance.

2           On the right, you can see growth in costs above  
3 the out-of-pocket threshold, shown in orange. In 2018, 41  
4 percent of spending was in the catastrophic phase, paid  
5 mostly by Medicare. That's more than double the share in  
6 2010. The pipeline shift, changes to Part D's benefit  
7 structure, and misaligned incentives have all contributed  
8 to this trend.

9           Over time, these factors have led to a situation  
10 in which plan sponsors are responsible for much less Part D  
11 benefit spending than they were at the start of the  
12 program. We borrowed the idea for this slide from a recent  
13 article by Erin Trish, Paul Ginsburg, and colleagues. On  
14 your left we compare our estimates of the distributions of  
15 Part D claims costs net of rebates for beneficiaries  
16 without the low-income subsidy in 2007 and 2017. On your  
17 right are similar distributions for LIS enrollees. We  
18 don't have detailed rebate data, so for this we assumed  
19 that plan and Medicare reinsurance spending was reduced by  
20 the average percentage rebates reported in the Medicare  
21 Trustees report. We applied the same percent rebates to  
22 non-LIS enrollees and LIS enrollees.

1           If you focus on the blue portions, we estimate  
2 that among beneficiaries without the low-income subsidy,  
3 plans' responsibility for net spending decreased from 53  
4 percent in 2007 to 29 percent by 2017. Among LIS  
5 enrollees, plan liability fell from 30 percent of net  
6 spending to 19 percent. Notice that Medicare's cost-based  
7 payments in gray (reinsurance on the left-hand side and the  
8 combination of reinsurance plus low-income cost sharing on  
9 the right) have increased substantially.

10           In 2016, the Commission recommended a package of  
11 changes to address some of the same concerns we just talked  
12 about. The recommendation would phase in an increase in  
13 plans' liability for catastrophic benefits from the current  
14 15 percent to 80 percent while simultaneously increasing  
15 capitated payments in order to return to an incentive  
16 structure more like what we had at the start of the  
17 program. The package would also give plan sponsors greater  
18 flexibility to use formulary tools and would modify LIS  
19 cost sharing to encourage use of lower-cost products.

20           Subsequently, however, benefit design changes, an  
21 increase in the brand coverage gap discount, and increased  
22 spending for specialty drugs have further reduced plans'

1 incentives to manage spending. In some cases, the changes  
2 encouraged preferential formulary treatment of high-priced,  
3 high-rebate drugs, which increases both program costs and  
4 premiums. The focus on rebates may also have affected how  
5 some manufacturers price their products.

6           To show you how incentives are misaligned, let's  
7 look at the benefit structures for enrollees without the  
8 low-income subsidy on the left and with the LIS on the  
9 right. These figures depict the benefit for brand-name  
10 drugs and biologics. The region between the initial  
11 coverage limit and the out-of-pocket threshold is called  
12 the "coverage gap."

13           As you can see, in the coverage gap, plans, shown  
14 in blue, are responsible for just 5 percent of brand  
15 spending on the left and, on the right, none of the  
16 spending for LIS enrollees. Plan liability is 15 percent  
17 in the catastrophic phase for both types of enrollees.  
18 Based on CMS data, rebates on brand-name drugs average  
19 nearly 30 percent. That means for some brand-name  
20 products, the value of rebates exceeds plan's benefit  
21 costs.

22           Another thing to note is that for beneficiaries

1 without the LIS on the left, the 70 percent manufacturer  
2 discount in the coverage gap applies only to brand-name  
3 drugs. For generic drugs, plans are liable for 75 percent  
4 of the costs in the coverage gap. This artificially lowers  
5 brand prices relative to generics, distorting price  
6 signals.

7           There's no manufacturer discount for LIS  
8 enrollees on the right. Medicare's low-income subsidy pays  
9 for the cost sharing throughout the entire coverage gap.

10           In addition, Medicare's reinsurance pays for 80  
11 percent of the costs above the out-of-pocket threshold.

12           So, what this shows is that the current structure  
13 doesn't provide strong incentives to push back on high  
14 prices or to manage spending for high-cost beneficiaries.

15           One way to restructure the benefit would be to  
16 eliminate the coverage gap and make plans liable for a  
17 consistent 75 percent of the benefit up to the out-of-  
18 pocket threshold for all beneficiaries.

19           In the catastrophic phase, Medicare would provide  
20 lower reinsurance, and the remainder would be a mix of plan  
21 liability (which would be financed through a higher direct  
22 subsidy) and a new manufacturer discount.

1 MS. SUZUKI: Potential reforms consist of two  
2 major changes that build on the Commission's 2016  
3 recommendations.

4 The first set of changes would revise the defined  
5 standard benefit for all enrollees and make plans  
6 responsible for a consistent 75 percent of spending between  
7 the deductible and the out-of-pocket threshold.

8 The second set of changes would restructure the  
9 catastrophic benefit to provide all enrollees with a  
10 complete insurance protection and shift insurance risk from  
11 Medicare to plan sponsors and manufacturers.

12 These changes would restore the risk-based  
13 approach envisioned for the program and eliminate  
14 structures that distort market incentives for plan sponsors  
15 and beneficiaries.

16 Both sets of changes are integral to ensuring  
17 that plan incentives are better aligned with Medicare and  
18 that they are consistent throughout all benefit phases.

19 Here is an example of the parameters of a  
20 restructured benefit compared with the current benefit. We  
21 are hoping this would help facilitate your discussion  
22 today.

1           In this example, we kept the annual out-of-pocket  
2 threshold to be roughly equal to the amount paid by  
3 beneficiaries under current law.

4           Focusing first on the top half, under the  
5 restructured benefit, the coverage gap discount that  
6 applies to non-LIS enrollees and the coverage gap for LIS  
7 enrollees would be eliminated. These changes would make  
8 plans responsible for a consistent 75 percent of spending  
9 between the deductible and the out-of-pocket threshold.

10           The restructured catastrophic benefit would  
11 eliminate enrollee cost sharing to provide complete  
12 insurance protection. Medicare's reinsurance is lowered  
13 from 80 percent to 20 percent as in our 2016  
14 recommendations. A new manufacturer discount would apply  
15 to brand and other high-priced drugs.

16           The 20 percent discount applied to all enrollees'  
17 prescriptions would have roughly offset the loss of  
18 coverage gap discount and the cost of the hard out-of-  
19 pocket cap in 2018. The remainder would be plan liability  
20 -- 60 percent for brand and other high-priced drugs and 80  
21 percent for lower-priced generics.

22           In thinking about the catastrophic benefit, I'd

1 like to draw your attention to two items.

2           First, the manufacturer discount, which is 20  
3 percent in this example, applies at the point of sale,  
4 meaning that the relevant price here is the prices they see  
5 at the pharmacy before any post-sale rebates are applied.

6           Second, plan and Medicare's shares would be  
7 calculated after accounting for post-sale rebates. So that  
8 means the actual plan share is a smaller share of gross  
9 spending than what's shown on the slide.

10           In order to help ensure a successful transition  
11 to a restructured benefit, we would need other changes.

12           Changing from the status quo would have a lot of  
13 moving pieces, and policymakers may want to phase in  
14 changes over time to allow plan sponsors to adjust to the  
15 new benefit structure.

16           Under the restructured benefit, it would be  
17 especially important for CMS to recalibrate risk adjusters  
18 because more of Medicare's premium subsidies would be  
19 capitated. There may be other ways in which to improve  
20 Part D's risk adjusters.

21           In addition to reinsurance, Part D also has risk  
22 corridors to protect plans at an aggregate level from

1 unanticipated losses. We may want to consider changes to  
2 the risk corridors, at least during the transition to the  
3 new benefit structure.

4           To ensure plan sponsors can effectively manage  
5 spending, the reforms would be accompanied by more tools  
6 and formulary flexibility.

7           Under the proposed reforms, CMS would need to  
8 recalibrate the risk adjustment model to reflect the higher  
9 benefit liability.

10           CMS has experience recalibrating the RxHCC model.  
11 They do this as part of the annual change in benefit  
12 parameters. They also have successfully recalibrated the  
13 model in response to ACA's phase-out of the coverage gap  
14 and in response to the recent increase in the manufacturer  
15 discount.

16           To see if the risk adjustment could accommodate  
17 the expansion in the LIS benefit, we looked at the  
18 distribution of spending and found that LIS enrollees have  
19 higher average spending than non-LIS enrollees, but  
20 variation in spending relative to average spending is  
21 lower.

22           This suggests that CMS would face no more



1 difficulty recalibrating risk adjusters to reflect spending  
2 for LIS enrollees than for non-LIS enrollees.

3           At the same time, because the model uses Part D  
4 claims, there is a lag between when major new therapies  
5 enter the market and when they are reflected in the  
6 adjusters.

7           CMS could investigate ways to incorporate those  
8 new therapies more quickly to minimize the large and  
9 systematic under- or overpayments for conditions.

10           We've talked a lot about Medicare's reinsurance,  
11 which applies at the individual beneficiary level. Now  
12 we're going to talk about risk corridors, which provides a  
13 cushion at the aggregate plan level. The risk corridors  
14 limit plans' overall losses when actual costs are higher  
15 than expected.

16           Given the higher insurance risk associated with  
17 spending in the catastrophic phase, we may want to consider  
18 enhancing the risk corridor protection temporarily during  
19 the transition period.

20           One option is to narrow the corridors during the  
21 transition to the new benefit, giving plan sponsors more  
22 protection against the risk of overall losses.

1           Similarly, policymakers could consider a  
2 temporary change in the shares of unexpected losses and  
3 profits borne by plan sponsors and Medicare in the  
4 corridors so that Medicare bears more risk during  
5 transition.

6           While the enhanced protection would be available  
7 to all plans, larger plan sponsors will generally have the  
8 member size to absorb the effects of unexpected changes in  
9 the pharmaceutical market. As a result, in practice the  
10 enhanced protection would be most valuable to plan sponsors  
11 with smaller membership size.

12           Consistent with our standing recommendations, the  
13 reform package would be expected to give plans new tools  
14 and flexibility to manage spending.

15           Most Part D plans use tiered formularies with  
16 differential cost sharing to manage spending, but LIS co-  
17 pays do not distinguish between drugs on preferred,  
18 nonpreferred, or specialty tiers. In November, we  
19 discussed differentiating LIS cost sharing for preferred  
20 and nonpreferred drugs.

21           Another tool that could become increasingly  
22 important would target specialty drugs. Part D plans can

1 apply higher coinsurance for drugs placed on a specialty  
2 tier.

3           As pharmaceutical pipeline shifts more towards  
4 higher-priced products, there may be value to allowing  
5 preferred and nonpreferred specialty tiers to encourage  
6 competition. It could also promote the use of biosimilars  
7 when they become available.

8           Another area that would benefit from more  
9 flexibility is protected classes. Medicare requires plans  
10 to cover all drugs in the six protected classes. This  
11 makes it harder for plans to obtain rebates and manage  
12 spending.

13           The Commission has previously expressed support  
14 for giving plans greater flexibility with protected classes  
15 as part of our 2016 recommendations and subsequently when  
16 CMS proposed a policy change that would make it easier for  
17 plans to manage spending for protected class drugs.

18           At the November meeting, several Commissioners  
19 raised concerns that higher nonpreferred co-pays would  
20 increase cost sharing for LIS beneficiaries and may affect  
21 their ability to obtain medications. The evidence on the  
22 access is mixed at best. We'd be happy to discuss our

1 findings on question.

2           Here, we'd like to highlight the multiple layers  
3 of beneficiary protection that exists in Part D. One such  
4 protection relates to CMS's formulary requirement that  
5 ensures broad coverage of medications.

6           CMS also reviews plan formularies to ensure that  
7 there is at least one therapy on a preferred tier, except  
8 when the class includes only specialty tier drugs.

9           That means LIS beneficiaries, like the other non-  
10 LIS beneficiaries, would only face higher cost sharing if  
11 the individual and his or her prescriber selected a  
12 nonpreferred product over the preferred therapy.

13           Another protection is Part D's exceptions and  
14 appeals process. Tiering exception is one type of  
15 exceptions under which patients can request a lower  
16 preferred cost sharing for a nonpreferred drug when  
17 medically necessary.

18           So, under the proposal, LIS beneficiaries with  
19 such medical necessity could request an exception from the  
20 higher nonpreferred copay.

21           While there may be room to improve the exceptions  
22 process, based on the available data, the majority of

1 appealed cases are approved in favor of the beneficiary.

2           Our goal today is to get your feedback on this  
3 policy direction.

4           Here, we've summarized the key components of the  
5 reform package. The first piece creates a consistent  
6 benefit below the out-of-pocket threshold. The second  
7 piece changes the allocation of financial risk in the  
8 catastrophic phase. Combined, they would provide better  
9 incentives throughout all benefit phases.

10           The key questions we are hoping to get your  
11 guidance on relate to the distribution of insurance risk in  
12 the catastrophic phase, and, related to that, is whether an  
13 alternative discount rate or formula should be considered  
14 and whether some of the other issues we discussed should be  
15 an explicit part of the reform package.

16           If there is a consensus to move towards a  
17 recommendation, we plan to come back in the spring with  
18 more specific policy language that reflects your discussion  
19 today.

20           DR. CROSSON: Thank you, Shinobu, Rachel, Eric.  
21 It's clear that you've done a lot of excellent work between  
22 the last meeting and today, including over the holidays.

1 So we really appreciate that work.

2 We're now open for clarifying questions. I see  
3 Brian, Bruce, Marge, Dana. Brian, Bruce, Marge, Dana,  
4 Amol.

5 DR. DeBUSK: First of all, great work. I'm a  
6 huge fan. I enjoyed both chapters.

7 I'd like to start my questions, though, on Chart  
8 6 of the presentation. I noticed we opened the chapter  
9 talking about with beneficiary cost sharing included, it's  
10 a \$97.5 billion spend, Part D. But when we look at the  
11 gross spending, it's \$168 billion in gross spending.

12 I'd always thought that the rebate was 27-ish  
13 percent nominally. I think the chapter even said 27  
14 percent. This looks like 40 percent to me, or is there  
15 something I'm missing on Chart 6? It looks like there's  
16 about \$68 billion that go away from gross spending to net  
17 spending, and where did that money come from?

18 DR. SCHMIDT: What 2018 -- sorry. My eyes are  
19 starting to --

20 DR. DeBUSK: Yeah. The two numbers add up to  
21 \$168.1 billion in gross spending in both phases, but then  
22 program spending, including beneficiary spending, is \$97.5

1 billion.

2 MS. SUZUKI: So these are gross spending, right?

3 DR. DeBUSK: Yes.

4 MS. SUZUKI: And the program spending does not  
5 include what's paid by beneficiaries in cost sharing and  
6 also does not reflect the rebates that plans get. So there  
7 are a couple of things that are not in the 80-ish billion.

8 DR. DeBUSK: Well, in the --

9 DR. SCHMIDT: And in addition --

10 DR. DeBUSK: The 97.5, though, I think that does  
11 include because enrollees paid \$14.2 billion of that 97.5.

12 DR. SCHMIDT: There's also the --

13 DR. DeBUSK: I'm just trying to tie the numbers  
14 because I kept noticing that we would do net spending some  
15 and gross spending some.

16 MS. SUZUKI: Yeah.

17 DR. DeBUSK: And it looks like there's about 68-  
18 ish billion dollars.

19 MS. SUZUKI: So we can get back to you on the  
20 breakout of the difference, but it's a little bit  
21 complicated. This really shows the total gross spending,  
22 and we were just saying there's some enhanced benefit

1 spending amounts that are reflected in the gross total.

2 DR. SCHMIDT: So that's supplemental benefits.

3 DR. DeBUSK: Oh, okay. So the difference -- so  
4 the rebates could be 27 percent, and the delta could be the  
5 supplemental benefits.

6 DR. SCHMIDT: Right.

7 DR. DeBUSK: So there's probably another -- 27 --  
8 30-ish billion in --

9 DR. SCHMIDT: There's employer spending in there  
10 too for wraparound coverage and other kinds of --

11 DR. DeBUSK: Okay. I was just trying to make the  
12 numbers tie because it looked like -- I mean, the rebates  
13 are astronomical. It just looked like they were even  
14 bigger than I thought they would be.

15 I guess then we'll have to do -- this will turn  
16 into a follow-up question too because on Chart 4 of the  
17 presentation, I was going to ask you to take the 2018  
18 column and sort of back me into what the gross spending  
19 would look like. But that's probably not a -- you could do  
20 it off the top of your head, but you're going to pretend  
21 like you couldn't. So we can do it in follow-up.

22 DR. SCHMIDT: It would be messy. So it's



1 probably best to come back to you.

2 DR. DeBUSK: Okay, okay.

3 Let me go through -- also, when we're talking  
4 about the coverage gap discount program and we're talking  
5 about the new program where we would charge manufacturers,  
6 is that based on price at the counter? That's the counter  
7 price, which is really close, Bruce was telling me, to the  
8 WAC, basically. For all intents and purposes, it is the  
9 WAC.

10 So final question, it looks like the coverage gap  
11 discount program, about \$9 billion, you know, what we would  
12 raise at the 70 percent threshold. In the reinsurance  
13 phase, it looks like you're collecting about \$20 billion,  
14 right? If you're about 20 percent? I mean, it looked like  
15 the rate went up. Where did that come from?

16 MS. SUZUKI: So 20 percent included covering the  
17 gap discount amount inflated for the 70 percent discount  
18 because the data was for 50 percent discount, and then  
19 there was the out-of-pocket cap cost, so converting the  
20 cost sharing amount or long-term cost sharing amount into  
21 the basic benefit cost.

22 DR. DeBUSK: It just looked like the amount of

1 money we were going to collect from manufacturers went up.

2 MS. SUZUKI: It did.

3 DR. DeBUSK: It looked like about 100 percent, a  
4 little more than 100 percent, or did I do the math wrong?

5 MS. SUZUKI: It's not quite 100 percent, but I  
6 think what we started out with was data on 50 percent  
7 manufacturer discount in 2018, which we inflated to reflect  
8 what would be under the 70 percent manufacturer discount.

9 DR. DeBUSK: And that got you to \$9 billion, I  
10 think.

11 MS. SUZUKI: Right.

12 And we also added on the cost of converting the  
13 cost sharing amount, which I think were a couple billion  
14 dollars for --

15 DR. SCHMIDT: So that the added new part of the  
16 benefit of having out-of-pocket cap, we needed a higher  
17 discount rate to pay for those benefits as well. We were  
18 trying to look at what rate it might require in a cap  
19 discount in order to cover that.

20 DR. DeBUSK: Okay. So the payments from the  
21 manufacturers under this new -- under this particular  
22 proposed arrangement would about double?

1 MS. SUZUKI: Relative to the 50 percent discount?

2 DR. DeBUSK: Yeah. Relative to the \$9 billion

3 now.

4 MS. SUZUKI: Oh. Relative to 70 percent?

5 DR. DeBUSK: What would the new number be?

6 MS. SUZUKI: I can go back and check. I don't

7 think it quite doubled the amount because it would apply

8 only to the brand -- our calculation reflected just on

9 average, just brand-name drugs in the catastrophic phase,

10 which is not the entire gross spend. And we thought it

11 added to about 9-plus, couple more billions to reflect the

12 out-of-pocket cap, but we --

13 DR. DeBUSK: Oh. So it's pretty close to a wash,

14 then. The money is pretty close to even?

15 DR. SCHMIDT: Right. So, again, it was designed

16 -- we were trying to find what rate it would take --

17 DR. DeBUSK: Okay.

18 DR. SCHMIDT: -- to accommodate what's now

19 coverage gap discount at the higher 70 percent rate plus

20 the new benefit of adding an out-of-pocket cap.

21 DR. DeBUSK: My mistake. In the reading -- I'm

22 glad I asked that question. In the reading, it appeared

1 that there was an increase in what we expected to collect  
2 from manufacturers, a pretty dramatic one, but I was  
3 mistaken.

4 Thank you.

5 DR. SCHMIDT: I think there was something in the  
6 reading saying that -- you know, we were trying to say  
7 we're not doing a cost estimate here. That's CBO's  
8 purview, and part of what they have to do is think about  
9 how the share of high-cost drugs will change into the  
10 future and what the distribution of spend will look like.  
11 So the exact -- there's some fuzziness around the exact  
12 discount rate one might need to cover this or that benefit.

13 DR. DeBUSK: Thank you.

14 DR. CROSSON: Thank you.

15 Bruce?

16 MR. PYENSON: Let me echo Brian's appreciation  
17 for all of this work. It's really, really amazing work.

18 I have a question on Slide 7, and I think,  
19 Rachel, you characterized this as after-rebate dollars.  
20 There's a 13 percent other in 2017 for non-LI population.  
21 What is that?

22 DR. SCHMIDT: So that's mostly the supplemental

1 coverage of employers and other small, like out-of-state  
2 assistance programs and that sort of thing.

3 MR. PYENSON: Ah, okay. Thank you.

4 To get to the post-rebate numbers, was that a  
5 uniform percentage by category or --

6 DR. SCHMIDT: Go ahead.

7 MS. SUZUKI: So we applied just a flat percentage  
8 rate across both populations, partly because I think  
9 depending on the drug classes, there could be higher or  
10 lower amounts. But we couldn't think of a consistently  
11 higher or lower reason for one population compared to the  
12 other.

13 So just to be conservative, we just said same  
14 rate, same rebate rate applies to both populations.

15 MR. PYENSON: How about within the verticals?  
16 The portion of rebate netting the federal portion, was that  
17 the federal portion of rebates netted against federal  
18 spending?

19 MS. SUZUKI: Exactly. So we used how CMS would  
20 calculate the DIR applied to reinsurance in order to come  
21 up with the figures.

22 MR. PYENSON: Okay. Thank you.

1           Another question. I think in 2017, the  
2 Commission looked at changes to the risk adjustment process  
3 where we recommended using two years of data, and I'm  
4 wondering if that's something you thought about for risk  
5 adjustment for Part D.

6           I think the focus of our earlier work was really  
7 Part C, but have you thought about that for Part D?

8           MS. SUZUKI: We have not, but we could certainly  
9 think about it in the future whether using two years' data  
10 improves the under- or over-estimate based on condition  
11 categories.

12           I think one thing we were highlighting is in the  
13 pipeline for the future year, which is not going to be in  
14 your data, there may be new drugs that are launched that  
15 would not be reflected and if there's other ways to  
16 account for that launch in the risk adjustment model as  
17 well.

18           MR. PYENSON: In particular, I think the  
19 disappearance of certain codes, like the apparent cure of  
20 diabetes in patients who just weren't coded, wouldn't be  
21 the issue so much of new drugs, but more relying on  
22 encounter data without coding optimization, I think, was

1 one of the dynamics we were looking at there.

2 Thank you.

3 DR. CROSSON: Thank you, Bruce.

4 Marge?

5 MS. MARJORIE GINSBURG: Thank you, and thanks  
6 also for such a fabulous report.

7 I have a very basic question on page 3. You  
8 mentioned that 44 percent are in MA plans, and 56 percent  
9 are in individual PDPs. I'm curious. Since only about a  
10 third of the population are in MA plans, how come 44  
11 percent are in drug plans affiliated with that, unless  
12 people who are in original Medicare, many of them are not  
13 purchasing Part D plans at all, which would then change the  
14 statistics? So that's question one is those statistics.

15 And the other is, do we ever separate out the  
16 drug use of the pattern of drug use of those in MA plans  
17 versus those who are in independent PDPs?

18 DR. SCHMIDT: I'll take the first one.

19 So to start out, I noted that about 74 percent of  
20 all Medicare enrollees are in Part D, so not everybody is  
21 in. So I think that's getting to why the MA share is  
22 higher.

1           The ones who are not in tend to either have  
2 either employer coverage or no coverage, and yes, they're  
3 probably more likely to be fee-for-service.

4           MS. SUZUKI: On the PDP versus MA-PDs, we do  
5 annually track the trends in the two populations in our  
6 June data book. MA-PD enrollees tend to have lower  
7 spending than non-PDP enrollees, and that's partly  
8 reflecting the population. The MA-PD enrollees are less  
9 likely to have low-income population. So some of that is  
10 that.

11           But even when you compare the same non-LIS  
12 population, there may be some differences, and we've seen  
13 generic use rate be slightly higher among the MA-PD  
14 population.

15           DR. CROSSON: Okay. Thank you, Marge.

16           Dana?

17           DR. SAFRAN: Thank you. This is momentous work.  
18 So thank you for these chapters.

19           My first question relates to some information you  
20 had in the chapter and you summarized on page 6 about the  
21 what's changed since 2006, and included there was brand  
22 manufacturers developing more high-priced specialty drugs



1 for very narrow populations.

2 I didn't see anything about what role, if any, we  
3 think that Part D had in stimulating that change, because I  
4 know when I was closer to this area of work was before  
5 implementation. And one of the biggest concerns was the  
6 challenges of getting manufacturers to develop therapies  
7 for small populations, rare diseases, et cetera. Do we  
8 think Part D has played a role in that shift?

9 DR. SCHMIDT: I suspect so.

10 You know, when the program began, all of a  
11 sudden, this big bolus of people had coverage, and we saw  
12 increased utilization. And at first, it was for the big  
13 blockbuster drugs for chronic conditions, and we saw a lot  
14 of spending associated with that. And I'm sure the  
15 manufacturers were happy, but they already had those  
16 products on the market. And then generics entered in the  
17 2010, especially 2012 time frame. There was a big cliff,  
18 all of a sudden, where a lot of patent exclusivity ended  
19 and people, the plans and pharmacists are just switching  
20 people over to using generics. And so there went a whole  
21 lot of revenue, right?

22 But now you still have people with a lot of

1 coverage, the Medicare population and D in particular. So  
2 I'm sure that probably motivated investment in things like  
3 oncology treatments and other smaller population drugs.

4 DR. SAFRAN: Yeah. Okay, thanks. I think that's  
5 an important piece.

6 DR. PAUL GINSBURG: Dana, not in too much depth,  
7 but the regulatory environment, FDA approval, as many  
8 people have said, has had a big impact on the shift towards  
9 drugs for small populations, rare diseases, because it's  
10 less expensive to get them approved. Exclusivity is  
11 longer. So it's really hard to sort, and I don't know when  
12 those changes happen.

13 DR. SAFRAN: Yeah. Thank you, Paul.

14 Okay. A second question I had relates to what  
15 you show on Slide 10 about the proposed restructuring. I'm  
16 curious what impact you've considered that this might have  
17 on plan premium, you know, as plans take on this greater  
18 liability. It's striking in the chapter -- and you had a  
19 visual of it -- that premiums -- despite what's been  
20 happening with spending, premiums have stayed at about that  
21 \$30 mark, which is quite remarkable. I found myself  
22 wondering how has that been possible, and then you look at

1 what the plan liability has been over time. And you start  
2 to understand why it's possible.

3           So I then look at this, and I wonder what do we  
4 expect to happen and what have you thought about in your  
5 modeling around plan premium costs.

6           DR. SCHMIDT: So the answer to that partly  
7 depends on the parameters selected, right? The answer  
8 depends partly on the parameters you select for things like  
9 the manufacturer discount in the catastrophic phase, but I  
10 think you're probably alluding to that over time, we might  
11 see -- if more of the spending continues to be in the  
12 catastrophic phase of the benefit and now beneficiaries  
13 have no out-of-pocket spending in that region, that  
14 probably will lead to some premium increases.

15           DR. SAFRAN: I'm going to hold it there, but I  
16 have other things, I think, that are better for Round 2.  
17 Thank you.

18           DR. CROSSON: Okay. Thank you.

19           Amol?

20           DR. NAVATHE: So, on that point, on page 21 of  
21 the reading, it sounded like you had done some estimates  
22 that increases in premiums by \$4.80 per month. At least

1 based on some parameters that we might pick, is that  
2 roughly what we would expect, which seems like it's about a  
3 12 percent increase in premiums?

4 DR. SCHMIDT: I think that piece of it was just  
5 associated with filling in the coverage gap.

6 DR. NAVATHE: I see.

7 DR. SCHMIDT: So, you know, throughout the paper  
8 there are different descriptions of where you might set a  
9 manufacturer discount, and again, these were estimates  
10 based on 2018 data alone. We can't do cost estimates. So  
11 this is just to give you a sense of things. And we'll have  
12 to -- if you come up with a package or a recommendation  
13 we'll have to go to CBO and ask for an estimate.

14 But this is to give you a sense of things. So  
15 there was one estimate of 15 percent, was to replace the  
16 current coverage gap discount of manufacturers, and then 20  
17 percent would accommodate both that and increased benefit  
18 spending associated with an out-of-pocket cap. And then  
19 there was a higher rate of -- I think it was 35 percent-  
20 ish, would cover the cost of filling in the coverage gap  
21 for all enrollees.

22 So that was to give you a sense of the range of

1 what a discount might need to be to cover all of those  
2 costs. If you had a lower discount on the order of 20  
3 percent and did not increase to cover the coverage gap,  
4 then it would require a premium on the order of 5 dollars a  
5 month. That was that estimate.

6 DR. NAVATHE: Great. Thank you for explaining  
7 that. And so I guess taking a step back, I have a few  
8 different questions. I want to definitely commend you for  
9 unpacking something that's very complicated and making it  
10 digestible, although I have to admit I didn't follow  
11 everything still.

12 So a couple of questions. So one thing is in --  
13 you did a sort of side box on the impact of cost-sharing on  
14 subsequent beneficiary behavior, patient behavior, in terms  
15 of acquisition. But because we're talking about premiums  
16 here, I'm curious if we've done any review also on the  
17 effect of premiums on participation, because that may end  
18 up being a pretty important piece of sort of a data point  
19 for us to also be considering.

20 MR. ROLLINS: So off the top of my head I can't  
21 remember studies that have been done on premiums, but I  
22 think one thing to keep in mind is, again, like Rachel

1 said, there's a lot of moving pieces here and so the net  
2 impact on the premium is unclear. But it's quite possible  
3 that the end result of this will be, even if premiums do go  
4 up, the increase may not be particularly large. So it's  
5 not clear that to the extent there is a feedback on  
6 participation, it may not be very substantial.

7           Also, there is evidence that people do  
8 periodically change plans in Part D, to some extent. It's  
9 not a huge number that change every year. But one factor  
10 that does seem to drive changes in plan behavior is if your  
11 premiums go up.

12           DR. MATTHEWS: And just one additional point if I  
13 could. There is an indirect example on the effect of  
14 premiums on people staying or leaving their Part D plan  
15 when an LIS beneficiary is in a zero-premium plan that  
16 experiences a premium increase, it is not uncommon for that  
17 beneficiary to stay in that plan and pay the additional  
18 premium.

19           DR. NAVATHE: Sort of a status quo bias, so to  
20 speak. Yeah. Okay. That's helpful. Thank you.

21           So a couple of truly clarifying questions. So  
22 one is, it looks like there's two different estimates for

1 plan liability when we look at 2007 to 2017, and I suspect  
2 I'm just missing what it is. So on Slide 7 here we saw 53  
3 percent going to 29 percent, and then on Figure 6, on page  
4 53 of the readings, there is a 75 percent to 40 percent  
5 plan liability estimate. And I suspect it's just I'm  
6 missing what the denominator is between them, but I was  
7 wondering if you could help clarify that. It was page 53,  
8 Figure 6 of the status report readings.

9 MS. SUZUKI: So one difference is we're  
10 separating the populations, so the one you're looking at is  
11 for non-LIS population. The figure you're talking about  
12 combines all of them. I think that is the primary, and  
13 this includes the premium.

14 DR. SCHMIDT: Right, and it's not just basic  
15 benefits on this one.

16 MS. SUZUKI: Right. So Figure 6 is limited to  
17 basic benefits, and we're trying to figure out what percent  
18 is paid on a capitated basis to plans. This figure, we did  
19 not separate out the supplement benefit component, so that  
20 also changes the denominator.

21 DR. NAVATHE: Okay. Thank you. Thank you for  
22 clarifying that.

1           One other question. So when we talked about risk  
2 corridors -- I forgot which slide you actually mentioned  
3 it, but you talked about it; I think it's Slide 15 -- the  
4 plans being fully at risk for less than 5 percent of the  
5 aggregated expected benefit cost, and I was curious if we  
6 have looked at -- I guess this would have to be some sort  
7 of modeling -- what that would translate to in terms of the  
8 plan risk. Effectively if we try to calibrate it to the 53  
9 percent, 29 percent type number, what would we expect that  
10 risk corridor level to roughly look like to give us some  
11 sense of what that threshold actually means for a plan.

12           MS. SUZUKI: So one maybe clarification. So the  
13 5 percent is the corridor percent, right, and when the  
14 program began, I believe the corridor was narrower, the 2.5  
15 percent around their bid. And so we were thinking there  
16 could be something similar that you narrow the corridor so  
17 the protection starts earlier. And one other justification  
18 for that would be that what's in the corridors would  
19 increase, in dollar terms, relative to what's in the  
20 corridor currently. So even the 2.5 percent may be similar  
21 to what's protected under corridors but 5 percent.

22           DR. DeBUSK: On that, what percentage of plans



1 hit their upper risk corridor in 2018?

2 DR. SCHMIDT: We don't know that yet. We don't  
3 have the information. We haven't been able to get much  
4 detail about that information for the past several years.  
5 But --

6 DR. DeBUSK: Over 50 percent hit their upper  
7 corridor, though, don't they?

8 DR. SCHMIDT: Through 2015, we know that's  
9 definitely true.

10 DR. DeBUSK: So over half the plans blow out the  
11 top end of their risk corridor.

12 DR. SCHMIDT: Right.

13 DR. DeBUSK: Okay.

14 DR. NAVATHE: So --

15 DR. CROSSON: Let's see. Where are we?

16 DR. NAVATHE: Sorry.

17 DR. CROSSON: You're still up?

18 DR. NAVATHE: No, I wanted to just clarify on  
19 this point. So, okay. So I think I understand the concept  
20 of the risk corridor, but at the end of the day, so when  
21 you look at the aggregate spending, we should be able to  
22 back out what the overall plan liability would have been,

1 given that they're capped at 5 percent, or whatever they're  
2 capped at. And so that would be -- that may not be  
3 something that we have off the top of our heads but I think  
4 it may be helpful to interpret that estimate. Otherwise,  
5 the 5 percent sort of lives in its own sphere. So if we  
6 don't have that maybe that would be helpful.

7 I'm done. Thanks.

8 DR. CROSSON: Okay. So Warner, I saw your hand.  
9 On this point or are you just --

10 MR. THOMAS: I just have a couple of quick  
11 questions.

12 DR. CROSSON: Okay. All right. And then Kathy.  
13 And so we've got Pat, Jon, Larry, Warner, Kathy. We're now  
14 approaching an hour for the question phase here, so I'd ask  
15 you to be relatively brief so we can get on to the  
16 discussion. Thanks.

17 Pat?

18 MS. WANG: This is a question on the cap  
19 discount. On page 26 -- and you referred to it just now --  
20 elimination -- so 20 percent is the number that has been  
21 kind of used for purposes of modeling or what have you, but  
22 there's a reference on the top of page 26 that if one were

1 to consider the elimination of the coverage gap for LIS,  
2 the cap discount would be 35 percent.

3           So I just wanted to ask you to explain a little.  
4 I'm not sure I fully understand. So the 35 percent would  
5 represent across LIS and non-LIS? Okay. What if it were  
6 just LIS? How big would it have to be to sort of capture  
7 the elimination of --

8           MS. SUZUKI: Are you talking about how -- what  
9 percent rate is needed to cover what's currently LICs?

10          MS. WANG: Yeah.

11          MS. SUZUKI: So what we estimated from the 2018  
12 data is that roughly a 15 percentage point difference  
13 between doing everything but the LICs phase-out for the  
14 coverage gap. And so 35 was including everything. Twenty  
15 was the number that just offset the current coverage gap  
16 discount, and the cap on the out-of-pocket costs.

17          MS. WANG: Right. Okay. So thank you. So I  
18 guess what I'm trying to get at is, because this modeling  
19 is sort of averaging across LIS and non-LIS, and I'm trying  
20 to understand better what it would actually be like. Let's  
21 say that there's a plan that is exclusively serving LIS.  
22 So if the cap discount is 20 percent, if the cap discount

1 is 35 percent, what I'm trying to get at, is there a  
2 differential impact on -- let's, in my example of a plan  
3 that serves exclusively LIS -- is there a differential  
4 amount of risk shift that is going to the plans serving the  
5 LIS?

6 MS. SUZUKI: We can try to take a look. I think  
7 part of the thing we need to think about is how much of the  
8 spending for the LIS population is in the catastrophic  
9 phase versus the below the threshold, and to date, more  
10 people, more LIS population reaches the catastrophic phase  
11 and they do account for the majority of spending. So in  
12 that case, the more people you have in the catastrophic  
13 phase, the more you would get out of the 20 percent  
14 discount, because you have more spending in that phase.

15 So it's not clear whether it would be less for a  
16 plan with more LIS.

17 MS. WANG: I guess I'm trying to understand the  
18 relative situation that a non-LIS plan is facing in terms  
19 of proportionately. Would a plan with non-LIS be accepting  
20 less of a risk shift than a plan with LIS, if you were to  
21 maintain the same cap discount that is averaged across both  
22 types of plans.

1 DR. SCHMIDT: So remember, though, that -- so for  
2 non-LIS enrollees in the coverage gap that their plans are  
3 liable for 5 percent on brand-name drugs. So it's not much  
4 more than what the LIS-heavy plans have too. So I think  
5 it's fairly sizeable risk in both cases.

6 MS. WANG: Is there -- I guess where -- and I'm  
7 just really asking because I just really don't know -- is  
8 there -- the whole approach towards this has been LIS and  
9 non-LIS have different benefit structures, which is well  
10 illustrated in the different pictures. The thrust of this  
11 is to have one unified benefit structure that covers both  
12 LIS and non-LIS, and I'm trying to tease out whether there  
13 is a differential impact proportionately on plans  
14 predominantly serving LIS members, because maybe more risk  
15 is shifting to them.

16 I mean, there's risk in general because of the  
17 need for the population and the high level of spending and  
18 the vulnerability of the population, but is there something  
19 in the structure of the cap discount and the idea of  
20 homogenizing everything that will have different impacts,  
21 better or worse, for plans that are in this different  
22 benefit structure today?

1 MS. SUZUKI: And we can definitely think about  
2 the impact separately on the cap discount. So one  
3 statistic we have in the past is that two-thirds or more of  
4 the spending in the catastrophic phase is incurred by low-  
5 income population. So you're taking, let's say, 20 percent  
6 of that in manufacturer discount for the LIS population  
7 versus the one-third that's non-LIS times the 20 percent.

8 So there is going to be a differential impact  
9 depending on the usage of the drugs in the catastrophic  
10 phase and how much of that is brand or high-priced  
11 products. So we'll definitely think about that.

12 DR. CROSSON: Okay. We've got Jon, Larry,  
13 Warner, and Kathy. Jon?

14 DR. PERLIN: Thanks. Let me agree with Dana's  
15 framing. Momentous work.

16 Every proposal is predicated on intended effect.  
17 I did a search for both the Part D status report and the  
18 proposal on the terms unintended consequence, and I only  
19 found one reference, and that was Lieberman, Chowdhury et  
20 al. on the original Part D.

21 But what should we be thinking about as potential  
22 unintended consequences here, in this, as we contemplate

1 this?

2 DR. SCHMIDT: So I think Dana pointed to one  
3 thing, which was the potential for, over time, premiums to  
4 increase, and perhaps that's appropriate, though. If  
5 benefit spending is increasing and the government is  
6 subsidizing roughly 75 percent, then, you know, premiums  
7 might want to rise proportionately, because that's how the  
8 program is structured, unless you want to recommend  
9 something different.

10 We've also heard from Commissioners in the past  
11 the focus on if there's more risk borne by plans, smaller  
12 regional plans are fearful that they may not be able to  
13 bear that much risk and it might lead to consolidation.  
14 Those are sorts of things.

15 Another potential we've tried to address by  
16 looking at least at literature and thinking about is what  
17 might happen with respect to increased -- or differential  
18 cost-sharing for the low-income subsidy enrollees. You  
19 know, would they be less likely to remain adherent or not?  
20 And the literature on that, I think we showed you, was  
21 somewhat mixed, but the policy that we were suggesting to  
22 go hand-in-hand, which would be to have preferred and non-

1 preferred differential on the LIS cost-sharing would be  
2 applied in situations where there was a choice of  
3 therapies. So not necessarily leaving somebody with just  
4 higher prices. There would be another alternative, or they  
5 could seek an exception.

6           So those are the main unintended consequences.  
7 We didn't label things as such because we were trying to  
8 think through, as you prompted us at an earlier meeting, to  
9 think through what the unintended consequences might be.

10           DR. PERLIN: I appreciate that. As I think about  
11 it now I also wonder about the interplay not only within  
12 the dynamic of Part D itself but the dynamic with, say,  
13 Part B, as well, and even effect on drugs may, to the  
14 limited extent, is there -- I just get the sense of, you  
15 know, sort of push and pull. But thank you.

16           DR. CROSSON: Thank you, Jon. Larry.

17           DR. CASALINO: Thanks. Would it be possible to  
18 provide a bit more information, maybe with some simple  
19 modeling, on the likely annual out-of-pocket costs to LIS  
20 and non-LIS beneficiaries, kind of on average, and then  
21 maybe an example of someone who had a very low need for  
22 expensive medicines and someone who had very high, again,



1 LIS versus non-LIS. And so both their premium costs and  
2 then their -- which you'd have to kind of guess at what  
3 happened with those -- and their just out-of-pocket copays  
4 for drugs, what that might look like, on average, and then  
5 kind of high cost and low cost scenarios for LIS and non-  
6 LIS. I don't think you've already done that, at least that  
7 I've seen, or have I forgotten?

8 DR. SCHMIDT: No, we haven't done explicit  
9 modeling like that, at a beneficiary level, but yeah, I  
10 think the general outcome of this approach -- and again,  
11 depending on what parameters are selected for how the  
12 manufacturer discount is, how the distribution of risk  
13 looks in the catastrophic phase, it might tend to be that  
14 all enrollees pay a slightly higher premium to cover things  
15 like what's now a coverage gap, and higher benefit spending  
16 in the unified benefit. But those enrollees who have very  
17 high spending out-of-pocket today, because they're paying 5  
18 percent indefinitely for high-priced drugs, would have a  
19 hard out-of-pocket cap. So they're going to see a really  
20 strong benefit there.

21 DR. CASALINO: Yeah. I mean, I think if I was a  
22 congressperson, I might be really interested in seeing what

1 these numbers would look like, just not meant just for the  
2 program but for my constituents. You know, what would be  
3 likely to happen. And I suspect some of them -- some of  
4 the numbers might look really good, for the reason that you  
5 just gave. But then for the LIS population, there's quite  
6 a bit of discussion in the report on even a very, very  
7 small increase in out-of-pocket costs might make quite a  
8 difference for people with chronic disease. And we had  
9 some debate about that at the last meeting. It might just  
10 be nice to see some numbers modeled as best you can model.  
11 I'm not talking about extension modeling. Almost more back  
12 of the envelope, based on your preferred structure for the  
13 restructuring of Part D.

14           And just a couple of very minor things. There is  
15 a sentence here -- I didn't mark the page number -- where  
16 beneficiaries can request an exemption. I think we  
17 discussed that a little bit last time. Generally speaking,  
18 it isn't the beneficiary who is going to request an  
19 exemption. It's the physician.

20           And this may seem like a small point, but we did  
21 discuss it last time. I think physicians feel that every  
22 day one more unpaid job gets given to them. And while it

1 may seem trivial to non-physicians, again, when you're  
2 talking to medical group leaders, when I asked them, can  
3 you just ask your people -- can you just have your people  
4 do one little thing, your physicians, and they say, "The  
5 physicians tell me, with gritted teeth, not one more  
6 thing." So just the language, I think, would be irritating  
7 to any physician.

8           And then two other -- one other language thing  
9 and then one other quick request.

10           Page 36 toward the bottom, I think -- I know you  
11 don't mean it this way, but I think to anyone who reads it,  
12 it might seem like an exceptionally cruel sentence, really.  
13 "Researchers found that for people with chronic conditions  
14 such as diabetes or schizophrenia, higher cost sharing for  
15 prescription drugs is associated with higher medical costs  
16 for services like inpatient care and emergency care."  
17 That's not cruel. This is the cruel one. "However, it is  
18 not clear if these added medical costs" -- in other words,  
19 these people are having to go into the hospital because  
20 they don't have their meds -- "are high enough to offset  
21 the lower spending in prescription drugs." I don't think  
22 you mean this, but it sounds like we're recommending, okay,

1 if Medicare can spend less on prescription drugs, it's okay  
2 if people wind up with unnecessary hospitalization. I know  
3 that's not what you mean, but it reads that way.

4           And just a last thing. In your appendix, you  
5 talk about the possibility of electronic prior  
6 authorization, and toward the end of that, the next to the  
7 last paragraph or so, you talk about how basically EHR  
8 systems, if I understand you properly, are set up  
9 deliberately to exclude competitors, so Optum won't allow  
10 electronic communication with CVS, Surescripts won't -- and  
11 so on. Is there any way that you can imagine that Medicare  
12 could -- we've had now many years of kind of EHR makers on  
13 their end and health plans on their end blocking access to  
14 competitors, and, again, it raises the effort for  
15 physicians considerably to request these prior  
16 authorizations or exemptions. Is there any way that you  
17 can imagine that Medicare could require that to participate  
18 you can't do that?

19           DR. SCHMIDT: I think Karen might be able to  
20 answer some of these issues better than I can.

21           DR. DeSALVO: About how the technology can  
22 support the front line?

1 DR. CASALINO: The technology can do it. It's a  
2 business decision, right?

3 DR. DeSALVO: Yeah, it is, and thank you all for  
4 the appendix, by the way, in the chapter talking about some  
5 of the strategies. Yeah, I mean, it's culture and business  
6 decisions, I think some of it is, absent understanding that  
7 sometimes the technology can be embedded in the work flow  
8 and improve what we want to do. Doctors have a knee-jerk  
9 reaction, probably appropriately, to saying not one more  
10 thing, which is what you're saying Larry. And I don't  
11 think the technology feels as seamless as it should. Even  
12 if it's technologically feasible, a lot of systems are  
13 choosing not to facilitate that for obvious reasons.

14 DR. CROSSON: Okay. Sorry. Warner.

15 MR. THOMAS: Jay, I'm going to hold until Round  
16 2.

17 DR. CROSSON: Okay. Kathy, last question.

18 MS. BUTO: A quick question, really the flip side  
19 of what Pat was getting at, which is before beneficiaries  
20 hit the catastrophic cap, I'm wondering if you feel  
21 confident, having read the chapter -- it feels like you do,  
22 but that the risk adjuster plus potential narrowing of the

1 risk corridors and some additional cost sharing for LIS  
2 beneficiaries is sufficient to give plans the tools they  
3 need, especially those plans that have a lot of LIS  
4 beneficiaries, sufficient tools to absorb that 75 percent  
5 risk for those beneficiaries. I wonder if you have a  
6 comment on that.

7           MR. ROLLINS: I think that's right, and we talked  
8 about this some at the presentation we did in November. We  
9 interviewed a number of plan sponsors about sort of taking  
10 on more risk in different phases of sort of drug spending.  
11 When we asked specifically, you know, how do you feel about  
12 if you were responsible for spending in what is now the  
13 coverage gap for the LIS population, by and large they  
14 seemed to think that was going to be a fairly manageable  
15 reform for them in that, you know, constrained range of  
16 spending, so they had a fairly good handle on sort of what  
17 their spending profile would look like in that range, and  
18 the sort of judgment seems to be that that was something  
19 that sort of could be picked up in the risk adjustment  
20 system.

21           MS. BUTO: So I'm just wondering. The risk  
22 adjustment system would suggest that spending -- there's

1 little variation in the spending for the -- it's higher per  
2 LIS beneficiary, but not much variation. It also suggests  
3 there isn't much room for, I guess, managing or influencing  
4 LIS beneficiary prescriptions. So that's why I wondered if  
5 plans, particularly those that have a high concentration of  
6 LIS beneficiaries, would feel they could really manage that  
7 risk.

8 MR. ROLLINS: The sense we got was that they  
9 thought they could.

10 MS. BUTO: Good, and you talked with high-LIS  
11 concentrated plans.

12 MR. ROLLINS: We did talk -- yes.

13 DR. CROSSON: And so one implication of that --  
14 and I'll use this as a transition statement for the next  
15 section -- is as we put together this package, because  
16 that's what it is, for March and April, to what degree do  
17 we want to -- and you'll see this on Slide 18. To what  
18 degree do we want to include in our, and I would say, bold-  
19 face recommendations some of these elements that we think  
20 need to be there in order for this to work for those plans?

21 So having said that, let's throw up Slide 18,  
22 which is, I think, the listing of some of the specific

1 questions that the staff would like to get responses to, in  
2 addition to the general issue of support for this  
3 direction. And I think Paul has volunteered to begin.

4 DR. PAUL GINSBURG: Thanks, Jay. Let me also  
5 give my praise to the team up there for the really terrific  
6 work they've done on this. And I was struck when I was  
7 reading it about how responsive it was to our discussion in  
8 November and the issues that came up there.

9 To me, this is the most important policy topic  
10 that we're taking up in this cycle, and it's perhaps  
11 ratified by the size of the audience at the moment. And,  
12 you know, I think what we're talking about is that when  
13 Congress passed legislation that set up Part D in 2003,  
14 they opted for a private plan approach, that they decided  
15 not to do a single payer approach for prescription drugs  
16 the way Medicare does for hospital and physician services  
17 but to go with private plans that would be at risk. And to  
18 me, three things that have happened, as you've sketched out  
19 in the paper, since the implementation have really  
20 compromised the essence of the structure that Congress set  
21 up with private plans, and the three are: the policies to  
22 reduce the impact of the doughnut hole through substantial



1 manufacturer discounts that, you know, reduce the risk that  
2 plans faced. Another one was the growth of rebates for  
3 certain drugs, which created the situation where plans  
4 sometimes have incentives now to actually push the highest-  
5 priced drugs because of the rebate structure. And then  
6 also the development of new, very expensive drugs, price  
7 increases for existing expensive drugs have pushed so much  
8 more of the spend into the catastrophic phase.

9           So I think there's really some urgency in doing  
10 something about this because the Part D approach has been  
11 undermined. I think the risk corridor approach that you  
12 sketched out will be very useful in transition, especially  
13 for the smaller community-based MA-PD plans. And the  
14 questions you pose on this slide about the parameters, my  
15 sense is that we should devote all our energy to the  
16 structure of the reform and not get hung up on exactly what  
17 percentage in the catastrophic phase the manufacturer  
18 discount should be. I think we're best off with examples,  
19 and if Congress takes this up, they'll decide how much  
20 savings they want to get, and, you know, the politics of  
21 the moment, and they will choose the parameter. But to me,  
22 the important thing is this change in structure that has

1 been laid out.

2 DR. CROSSON: Okay. Thank you, Paul.

3 We'll now start the discussion. I see Brian --

4 okay, let's see. We'll start over here. Brian, Dana, Pat,

5 David, Jon, Warner, Jaewon, Kathy, Bruce, Amol. Everybody?

6 And did you get that nameless person down at the end?

7 [Laughter.]

8 DR. CROSSON: Okay. Brian.

9 DR. DeBUSK: First of all, thank you again for

10 fantastic work. I categorically support the

11 recommendations and the direction that this is going, so I

12 think it's wonderful work, and I was excited when I read

13 the early parts of it in 2016, and I'm even more

14 enthusiastic today.

15 I also want to echo Paul's comment. It is

16 remarkable how responsive you guys have been to some of the

17 issues that were raised in the previous meeting, so thank

18 you.

19 I think your chart on page 12 really summarizes.

20 I think it's an excellent template. You know, again, not

21 to get into the specifics, I think the 20 percent fee, if

22 you will, on manufacturers so that you can fund the out-of-

1 pocket gap as well -- I apologized earlier. I read your 15  
2 and 20 in the reading and read 15 billion and 20 billion,  
3 and I thought, oh, I wonder how we're going to get that  
4 money. So got it, completely square, and I think that's an  
5 excellent template.

6 I do want to focus on one thing. I do think  
7 adding a new co-pay in the LIS benefit for drugs that have  
8 a generic available where someone's making a conscious  
9 effort, I think adding that third co-pay is very reasonable  
10 and maybe even reducing the co-pays for the existing two,  
11 the 525 and 825 co-pays, something in that range. But,  
12 anyway, if we could maybe even reduce that and bring in a  
13 new co-pay for generic available drugs.

14 I do like the risk corridor treatment. I think  
15 that's an excellent idea. I'm still skeptical over how  
16 much risk any of these plans take, if over half of them hit  
17 their upper risk corridor every year, so I don't know if  
18 we're really dealing with what we would think of as risk to  
19 begin with.

20 And then my final comment was -- and you know  
21 what it's going to be -- please, please, keep chasing the  
22 rebates. Please follow the money, because there's 60-ish

1 billion dollars floating around here that is being  
2 allocated through that sort of arcane DIR formula. Any  
3 model that we do, at some point I hope we can do a little  
4 thought experiment and say, well, what if rebates were 80  
5 percent, not 27 percent, what would that do to our model?

6           I do think as long as the taxpayer -- and I'll  
7 circle back to why I like Chart 12 so much. I think with  
8 the taxpayer on the hook for only 20 percent, I think  
9 rebates are going to have to rise to such a high rate, and  
10 if you can tie that -- that's why I like the 20 percent  
11 manufacturer fee, because, you know, that's net -- that's  
12 not -- doesn't have the net rebate price in it. So, in  
13 theory, as they run up the rebate, not only does that  
14 create a drag on pricing just to run up the price, but if  
15 you don't tie it to the net rebated price, if it's the at-  
16 the-counter price, people who demonstrate this really bad  
17 rebate behavior are going to pay a larger and larger  
18 portion of -- you know, effectively their rate goes up from  
19 20 percent as their rebates go up with their price. I know  
20 I'm butchering that, but I don't know -- I suspect you guys  
21 did that intentionally. If you did, it's genius. If you  
22 did it by accident, which I seriously doubt, you're very

1 fortunate. But I do think that there's a lot of cleverness  
2 in the way you've done that, and I support it  
3 categorically.

4 DR. CROSSON: Yeah, I defaulted to genius on  
5 their part, but that's okay.

6 DR. DeBUSK: I agree.

7 DR. CROSSON: Dana.

8 DR. SAFRAN: Yeah, thanks. I really appreciate  
9 how Paul teed this up, and I guess what I want to also  
10 recognize, sort of the overarching theme of my comments,  
11 and it will sound familiar from last meeting, is, you know,  
12 it is striking that this is the area of the Medicare  
13 program where Medicare really doesn't have control over  
14 price, and so they're relying on plans for that function.  
15 So I do fully support the direction that you're moving here  
16 in trying to increase the accountability of plans. And  
17 several of the dimensions by which you're trying to do that  
18 I think are really wise. My concern will continue to be  
19 about unintended consequences, so my comments are in that  
20 spirit.

21 You know, one of the things I wonder about, you  
22 know, just staying on rebates, which both Paul and Brian

1 have mentioned, is I just wonder whether as a condition for  
2 participation we could require, Medicare could require  
3 fully transparent pricing from plans that want to  
4 participate. You know, why can't we do that? Because I  
5 think we have to address rebates, and we're not -- I didn't  
6 see it here. So throwing out that idea.

7           Then other aspects about price. I like how  
8 you're giving the plans more tools like tiering to address  
9 the use side. I think one of the things that I was  
10 thinking about in my previous question was this issue that  
11 premium prices do seem very likely to rise, and I liked  
12 your point, Rachel, that, you know, is that really a bad  
13 thing? You know, should to some degree beneficiaries be  
14 experiencing the underlying increasing costs that are  
15 happening and that are coming at us like a tidal wave with  
16 specialty drug development that's coming down the pike?

17           We have to put some boundaries and safeguards  
18 around that, so I think that's something to think about.  
19 But I think we have to expect that premiums are going to  
20 rise and deal with that kind of explicitly in the chapter.

21           I'll raise again an idea I put forward last time,  
22 and I think Jim had indicated it was in the chapter

1 materials, but I'm afraid I didn't see it if it was. It's  
2 this idea of a standard formulary because, since Medicare  
3 has yielded to the plans the price, I think we have to find  
4 a way that puts the plans in the position of putting  
5 pressure on the manufacturers around price. And the best  
6 idea I can think of for how we do that is that, as we do in  
7 the Medigap market, Medicare stipulates what the product  
8 has to contain, what it looks like, in the way of a  
9 standard formulary, and then the plans have to figure out  
10 how they can deliver that product at a price that will be  
11 market competitive.

12           I know that's too much for us to build into this  
13 chapter in the time frame that we have, but I would love to  
14 see us signaling that as a direction to be explored because  
15 it will become more and more necessary.

16           And then the final comment I want to make is that  
17 -- and I say it with some mixed feelings, but I am  
18 concerned about the zero cost share in the catastrophic  
19 phase. And, you know, it probably goes without saying, but  
20 just to be clear, I think we have ample evidence going all  
21 the way back to the RAND health insurance experiment that  
22 when care goes on sale, patients use more of it. And I

1 think that given that -- I think we have to be concerned  
2 with that because, unless the plan and the manufacturer who  
3 are then accountable in that phase, in the new structure,  
4 really are concerned about the overall price of the  
5 product, which I don't think our current structure has them  
6 having that concern, then there's really no one interested  
7 in avoiding unnecessary utilization in that phase that can  
8 happen. And I don't -- and you made the point in the  
9 chapter that we now have hundreds of thousands -- I think  
10 it was close to 300,000 beneficiaries last year who with  
11 one drug fill hit the catastrophic phase, right? So I just  
12 think we have to be really thoughtful about where we set  
13 cost sharing to zero and what happens, and those who are  
14 accountable for cost on the other side really have the  
15 incentives that we need them to have to worry about overall  
16 utilization.

17 Thank you.

18 DR. CROSSON: Thank you, Dana.

19 Pat?

20 MS. WANG: Just to pick up where Dana left off, I  
21 think that it's a very good point about cost share in the  
22 catastrophic phase, and I agree with her on that.



1           I want to thank you also for the evolution of the  
2 work here and the incorporation of a lot of Commissioner  
3 feedback. I mean, it's very rich, and I also just want to  
4 say I love your attitude towards unintended consequences  
5 and it's a problem to be solved as opposed to just like  
6 noting it.

7           A couple of things. In the landscape chapter,  
8 this is more of a request, I guess, for clarification at  
9 the bottom of page 48. There was a comment that because  
10 LIS pays for most of enrollees, out-of-pocket cost plans  
11 don't bear -- they have little incentive. There are two  
12 things that I would say there. One is don't forget the  
13 incentive of not having to use -- for an MA-PD not having  
14 to use Part C rebate dollars to buy down the Part D  
15 premium. Trust me, that is a powerful incentive to lower  
16 your Part D spending. It's huge. That's number one.

17           And the second is the landscape chapter, in a  
18 way, is the foundation for the restructuring chapter. I  
19 think it's important to note that they have little  
20 incentive or ability to really address this, because if you  
21 look back on slide -- whatever it is in the slides -- I  
22 guess it's 9, misaligned incentives in Part D. If you look

1 at the way LIS is structured, this to me is the tradeoff  
2 for saying to plans serving LIS members there are no tiers.  
3 Forget they have differential copays. There's no -- you  
4 can't even display drugs in a different tier. Currently,  
5 the rules, it's one tier, preferred generics, nonpreferred  
6 generics, all brands, all specialty. It's one tier with a  
7 fixed-dollar or zero copay.

8           And we've talked about the protected drug  
9 classes, so forth and so on. LIS beneficiaries use a lot  
10 of drugs, and I think it's -- and there's no manufacturer  
11 discount in the coverage cap. So this, in a way, this  
12 design matches the way that the benefit runs today, and I  
13 think that what's great about the restructuring chapter is  
14 that you're saying if this is going to change, those  
15 fundamental underlying tools for plans must change with it.  
16 So, to me, that is the linchpin of the restructure for LIS.

17           You made a point on page 27 of the Part D, of the  
18 restructuring chapter, that reinsurance has been used to  
19 counter sponsors to avoid high-cost enrollees. So I would  
20 add to the list of unintended consequences that really need  
21 to be emphasized and require a solution is if you're going  
22 to change reinsurance in a way that it is now, especially

1 for more vulnerable beneficiaries, risk adjustment is the  
2 replacement now to avoid that kind of selection and  
3 avoidance of beneficiaries that have certain conditions and  
4 that rely on certain types of drugs, frankly. And so I  
5 think that it can't be emphasized enough.

6           I also -- you know, what I heard Eric say about  
7 the plan interviews was -- and I may have misunderstood, so  
8 forgive me -- is that in the interviews, plans said that  
9 risk adjustment in the -- up to the out-of-pocket threshold  
10 for what's now the catastrophic, the 75 percent could be  
11 addressed by risk adjustment. I think that's probably  
12 true, at least from my perspective. The real question is  
13 what happens beyond that in the reinsurance level where  
14 spending is very, very big for LIS beneficiaries. Is it  
15 possible -- and which is now cost-based through the  
16 reinsurance design, the importance of risk adjustment  
17 addressing that and the spikes and the unexpected levels of  
18 spending in that reinsurance level.

19           Thank you for following up on the question about  
20 the size of the cap discount, and by the way, I feel that  
21 in this entire package of proposed reforms, the cap  
22 discount is probably the most significant piece. And

1 moving from the manufacturer discount to a cap discount is,  
2 to me, anyway, structurally the most meaningful change and  
3 very, very important. So I think that it's very important  
4 to pursue that.

5           On page 35 of the restructuring part, again,  
6 there's some conflation, I think. I think it would be  
7 helpful to do this in two steps. Again, it goes back for  
8 LIS. There are no tiers. It's not a matter of -- the  
9 chapter sort of jumps to maybe there should be differential  
10 copays for the different tiers. There are no tiers for LIS  
11 beneficiaries. So step one has to be that plan sponsors  
12 have to be permitted to display preferred, nonpreferred, a  
13 five -- they have to at least be able to display it. And  
14 step two is differential cost sharing. I think that's  
15 critical because, candidly, if people decide that they  
16 don't want to go there with copays, just even being able to  
17 display different drugs also for prescribers -- because  
18 there is absolutely no ability for anybody to know what's  
19 more expensive and what's less expensive today for LIS.

20           Then, finally, I would just continue to encourage  
21 us, you, please, to think about whether the redesign really  
22 does need to be the same and homogenized for LIS versus

1 non-LIS. I continue to think that there are reasons the  
2 size of the cap discount, some of the concerns around risk  
3 adjustment, et cetera, to have a differential benefit  
4 design for LIS particularly in the share borne by the  
5 parties in the catastrophic phase. So I just ask that we  
6 continue to be open to that.

7 Thanks.

8 DR. CROSSON: Thank you, Pat.

9 David?

10 DR. GRABOWSKI: Great. Thanks.

11 So I find Part D to be maybe the most complicated  
12 area in Medicare that we focus on here. So I really  
13 appreciate that I think these efforts are sort of  
14 increasing accountability and transparency, and I think  
15 this is a huge step forward. So I would say, overall, I'm  
16 very supportive of these reforms.

17 I won't go through -- Pat just made a great set  
18 of comments. I just want to pick up on one part of her  
19 comment, just emphasize that, and that's around the tools  
20 that you list out. I'm very supportive of that. I like  
21 the way you frame that. That has to be done, because right  
22 now there just aren't the set of incentives in place.

1           The preferred/nonpreferred, specialty tiers, the  
2 copays, yes, yes, and yes. Let's move forward with that.

3           So I'll stop there, Jay.

4           DR. CROSSON: Thank you, David.

5           Jaewon?

6           DR. RYU: Thanks.

7           I wanted to also echo the complexity on this is  
8 just astounding, which is why I like the set of proposed  
9 approach -- or recommendations. Slide 10, I thought  
10 summarizes it really well, and I think the simplicity of  
11 that compared against the complexity of what we have right  
12 now, I think it resonates.

13           I also appreciate the commentary in response to  
14 some of the concerns from the last discussion. In  
15 particular, I like the risk corridor idea as a way to sort  
16 of soften the transition, especially as it might impact or  
17 disproportionately impact smaller plans. So I appreciate  
18 that.

19           You know, I want to go back to something that  
20 Larry said, and I don't know if this is easily doable. But  
21 there's some commentary in the materials around we're going  
22 to assume behavior static and here's what we think the

1 impact would be. As we think about some of these levers,  
2 though, it almost begs the question, well, we know behavior  
3 won't be static, and in what ways might we expect or  
4 anticipate behavior to change of the various actors?

5           So as we look at the different levers and the  
6 structural proposal elements, I think it would be helpful  
7 if there was some sort of -- I wouldn't even call it  
8 modeling because I think that overstates what we need, but  
9 some sense of if this lever goes this way, we might expect  
10 to see Player A act this way and Player B act that way. I  
11 think that would just help to flesh out what some of the  
12 anticipated effects of this could be.

13           Then, lastly, just on the LIS and the copay  
14 differentiation, I think that's absolutely got to be -- you  
15 know, I'm in favor of all of them, but that one really felt  
16 very compelling. In particular, I think Brian mentioned  
17 earlier in scenarios where there is a generic alternative  
18 and yet no copay differentiation, I just feel like that's a  
19 miss that we should make sure finds its way alongside all  
20 the others, so thanks.

21           DR. CROSSON: Thank you, Jaewon.

22           Paul had a comment.

1 DR. PAUL GINSBURG: Yeah. I'm glad Jaewon  
2 brought up the issue of projecting behavior, because it's  
3 something I neglected to mention when I spoke first, which  
4 is that we've been focused about how plans will behave  
5 differently with their incentives to use more tools to  
6 steer their enrollees into the most efficient drugs.

7 This, of course, is going to flow through to drug  
8 manufacturers in their pricing decisions in particular, and  
9 that, I think, is a key part of this approach. You  
10 incentivize the plans, and you indirectly incentivize the  
11 manufacturers to not price so high. I think this is a key  
12 market-oriented tool in seeking lower drug prices,  
13 particularly for new drugs.

14 DR. CROSSON: Jonathan, I'm sorry. I jumped over  
15 you because I can't read that well. Go ahead.

16 DR. PAUL GINSBURG: I can't write that --

17 DR. CROSSON: He actually -- you don't know this,  
18 but he actually has an M.D. degree, and I thought that he  
19 was going to be writing clearly, which is something I can't  
20 do, but apparently, he's got a surreptitious M.D. degree  
21 somewhere in his background.

22 DR. JAFFERY: Well, I can appreciate that as I'm



1 looking through the notes that I wrote myself about a  
2 minute ago. I'm not sure I can read them.

3 [Laughter.]

4 DR. JAFFERY: Well, I want to echo what others  
5 have said and just in the interest of time just try and  
6 emphasize maybe a few points.

7 I really appreciate how you're trying to get back  
8 to this notion of the goal was to provide about a 75  
9 percent support for the Medicare program, yet at the same  
10 time try to create some stability and decrease some  
11 uncertainty for the plans.

12 I know talking to our own, some of the  
13 pharmacists in our own health plan, they comment about how  
14 over the last 5 to 10 years, they've gone from where year  
15 to year, they could really predict what costs would be.  
16 And now their ability to predict it is just less and less  
17 good each year and not necessarily in the same direction,  
18 and this is not a Part D thing, per se. This is -- they  
19 deal with a lot of commercial, probably more commercial  
20 than Medicare.

21 I also really appreciate Paul's point about maybe  
22 trying to get a way not too far in the weeds, the specific

1 numbers, but noting that Congress can and will and really  
2 must decide some of the specifics, and if we can get this  
3 sent to the general direction, the exact percentages may  
4 not be the most important relative to the overall  
5 structure.

6           Some of the things, the discussion questions and  
7 next steps that we haven't talked about as much, have been  
8 some of the alternative rates or formula indexed to  
9 different things. I think Bruce brought it up a couple  
10 months ago about how we might index the manufacturer's  
11 rebate, and there are different ways to do it. I mean, we  
12 could think about projecting that over even a particular  
13 drug cost or total costs to the beneficiary.

14           To me, that's one of the stickiest, trickiest  
15 things is thinking about the behavioral change that's going  
16 to come from manufacturers in response to the rebates, and  
17 if we may be driving prices up with some of these rebates,  
18 then how do we get some diminishing returns for them in  
19 that regard?

20           I really like the enhanced risk corridors for the  
21 plans for the reasons people have said, and I think this  
22 had come up in a previous discussion. I didn't quite see

1 it here as much, but there may be some thought given to how  
2 you would structure that, even on a longer-term basis,  
3 potentially for plans that have a higher percentage of LIS,  
4 depending on what we see with some of the ability to risk-  
5 project there.

6           Then, finally, Dana, I really liked what you were  
7 talking about in terms of getting to a standardized formula  
8 and also acknowledging that we can't probably do that right  
9 here, but thinking about projecting that. It comes back to  
10 some of the comments about giving plans tools. Maybe  
11 there's something at this point that can project in that  
12 direction that is a little bit more forceful about  
13 eliminating some of the protected classes or all of the  
14 protected classes, and it would start to -- this may be an  
15 interim step towards getting there.

16           And then, finally, my final comment will be about  
17 -- again, this goes back to Dana. You were talking about  
18 having no copays in the catastrophic phase. I do worry  
19 about out-of-pocket costs for beneficiaries overall. I'm  
20 open to thinking about ongoing, some type of copay, but I  
21 guess thinking about the fact that, as you said, there are  
22 over 300,000 people now who reach that phase in a single

1 month, that means that those folks are paying, as it's  
2 currently structured, 5 percent of what is a very, very  
3 expensive drug for another 11 months. And there are plenty  
4 of other people who get there in two or three or four  
5 months.

6           So I guess if we're going to have that, I would  
7 be less interested in a percent copay, which could still be  
8 very large, and maybe there's a monthly limit to a copay,  
9 even at a catastrophic phase for beneficiaries, so, again,  
10 they have some predictability and the potential for some  
11 prolonged affordability.

12           Thanks.

13           DR. CROSSON: Thank you, Jonathan.

14           Jim?

15           DR. MATHEWS: Yeah. Just to pick up on a couple  
16 of points of discussion that have occurred up to this point  
17 in time -- and I'm doing this because, after this meeting,  
18 we're going to have to go back and sort out the discussion  
19 and come back to you in March.

20           So I understand the intent and the potential  
21 benefit of developing a recommendation that lays out  
22 general direction with respect to the allocation of

1 financial responsibility in the catastrophic phase and not  
2 laying out specific percentages necessarily. I get that.

3 But a couple of Commissioners have raised the  
4 possibility or concerns about the hard out-of-pocket bene  
5 cap or the zero liability in the catastrophic phase.

6 Just a bit of history here, when we did our 2016  
7 recommendation, this was something that a couple of  
8 Commissioners felt quite passionately about, and it was for  
9 the reasons that, Jonathan, you just alluded to, that if a  
10 beneficiary has a condition or is in such a state of health  
11 that they are incurring that kind of cost in the  
12 catastrophic phase and especially if they are using sole-  
13 source drugs for which there are no alternatives, no  
14 competitors, that imposing cost sharing in the catastrophic  
15 phase isn't really getting the beneficiary to think about  
16 the cost of what they are using and whether there are low-  
17 cost alternatives available but rather -- and, again, I'm  
18 characterizing prior Commissioners' discussion here. This  
19 is simply punitive, that the 5 percent copay serves no real  
20 purpose with respect to getting the beneficiary or their  
21 clinician to evaluate alternatives.

22 So that is why, as we've crafted the current

1 package that you've been discussion, we have retained the  
2 hard out-of-pocket cap or the zero copay as a component of  
3 this package.

4           Obviously, if the Commission decides to take a  
5 different direction, we can pursue that, but it does get  
6 implicated in the overall approach of not specifying  
7 percentages, because when we do come back, we are going to  
8 have to say either no copay in the catastrophic or some  
9 copay in the catastrophic.

10           So, as the discussion proceeds from here, it  
11 would be helpful for me, again, as I go back and sort this  
12 out, to get a sense of where you want to be with respect to  
13 that specific element.

14           DR. DeSALVO: Just a clarifying question, Jim.  
15 Is part of the rationale for not having copay in the  
16 catastrophic phase because of the percent copay in the non-  
17 catastrophic phase? So there may have been a lot of out-  
18 of-pocket because of the high cost of the drug, so people,  
19 theoretically, meet the cap more quickly? And if you  
20 shifted out of a percent in --

21           DR. MATHEWS: I think again -- and I'm trying to  
22 articulate the concerns of a couple of prior Commissioners

1 -- it was more what purpose does it serve to require a  
2 beneficiary who is, you know --

3 Do you want to --

4 DR. SAFRAN: Yeah. So this is such a delicate,  
5 difficult issue, right, because this program was designed  
6 to protect beneficiaries from the financial harm of high  
7 medication cost.

8 On the flip side of that, we have to deal with  
9 the reality of a lot of evidence that shows that when cost  
10 sharing goes to zero, people will just use a lot of care,  
11 sometimes more care than they need. So how do we balance  
12 those two difficult things?

13 I don't think that -- you know, this is just me.  
14 I don't think the purpose of cost sharing, at least in the  
15 catastrophic phase, is to cause people to think about like  
16 which drug should they be on. I think it's more about  
17 having people consider the whole volume of drugs that they  
18 are on.

19 So I think that Jonathan's point that continuing  
20 with a percentage basis for cost sharing in the  
21 catastrophic phase may be a really poor idea. Given the  
22 kinds of drugs that often are landing people there, that

1 would just be a very high -- you know, but I think -- so  
2 there's copayments as opposed to coinsurance as a  
3 mechanism. There's Jonathan's idea about once you're in  
4 the catastrophic phase, a per-month cap on out-of-pocket  
5 cost, something like that.

6           If others agree that we should be thinking about  
7 something that isn't a hard cap and it goes to zero for  
8 whatever the rest of the year looks like, then I think  
9 there are ways to mitigate the concern that we all have  
10 that that not impose really terrible financial exposure for  
11 the sickest Medicare beneficiaries.

12           MS. BUTO: Jim, since I was here for that  
13 discussion I want to also mention another factor which  
14 entered into our recommendation, which is we were still  
15 dealing with the coverage gap. We decided that we would  
16 eliminating counting the manufacturer rebate to get to the  
17 coverage gap. And so what that ended up doing was having  
18 many beneficiaries never reach the coverage gap. So the  
19 quid pro quo, if you will, was for those who did reach it,  
20 because it was now a lot harder to get there, the copay or  
21 coinsurance would be zero.

22           Now this structure eliminates the coverage gap,



1 so I think it's fair game to go back and look at that  
2 again. But that was, at least for me, one of the strong  
3 reasons for going to zero, was to compensate for the fact  
4 that those who reached it were really going to be super  
5 expensive and have potentially put out a lot of out-of-  
6 pocket payment.

7 DR. NAVATHE: I would also say, from a clinical  
8 perspective, if we look at what's transpired over the last  
9 four years, the types of medications that are priced such  
10 that people would reach this -- you know, up to this  
11 catastrophic phase, probably there's a lot more medications  
12 where there is some discretion than we had even five years  
13 ago, in terms of disease management types of medications as  
14 opposed to, you know, more chemotherapeutics and the acute  
15 phase kind of things.

16 So I think there is probably some reasonable  
17 clinical rationale also to reconsider this piece.

18 DR. CROSSON: Okay. So we have Warner, Amol, and  
19 Larry, and then I think -- I'm sorry, then we missed Kathy,  
20 we missed Bruce. We missed you?

21 DR. DeBUSK: Yes.

22 DR. CROSSON: Okay. Sorry. So I think that will

1 do it, though. Warner, Amol, Larry, Kathy, Bruce, and then  
2 we need to end.

3 Warner?

4 MR. THOMAS: Yeah. I'll be brief. So on Slide  
5 12 I think you do a good job really outlining how this  
6 could work, and I would just -- you know, this is a really  
7 complicated topic. I would concur with Dana's points  
8 around having a standard formulary, because I think that's  
9 really important. The recommendation I would put out there  
10 is that we not necessarily cap the manufacturer discount at  
11 20 percent. I'm not sure why that wouldn't, you know,  
12 increase over time or be considered to be larger, given the  
13 size and scale of this increase over the past couple of  
14 years.

15 You know, I know we've talked before about, you  
16 know, Medicare doesn't really buy drugs in a lot of the  
17 program and in this one it does. And so should we be  
18 proposing in here some sort of inflationary cap that sits  
19 on, you know, drugs, and then that may kind of help  
20 mitigate the escalation in some of these costs and it may  
21 also play into that manufacturer discount. But, I mean,  
22 this idea of capping increased costs I think is -- this is

1 a program that really, I think, is in a good position to be  
2 able to do that, and given that cost escalation is  
3 significant.

4           So those are a couple of comments. I do agree  
5 with Dana that, you know, having -- I think there should be  
6 a zero cost-sharing option for folks, but I do also think  
7 the idea of having some cost-sharing on items that are more  
8 expensive, just so folks can understand, would probably be  
9 helpful, versus it just being zero for everything.

10           So that's just a couple of thoughts.

11           DR. CROSSON: Thank you, Warner. Amol?

12           DR. NAVATHE: So I generally want to echo support  
13 for a lot of the ideas the Commissioners have raised up to  
14 this point. We already talked about the cost-sharing, the  
15 catastrophic phase, and Warner's point about thinking about  
16 an inflationary cap on the manufacturer discount. I think  
17 that's also worth doing.

18           I think it would help -- I have kind of three  
19 core areas that would be worth looking a little further  
20 into. I think one of the pieces is we have talked about  
21 how important risk adjustment becomes, and I think Pat  
22 highlighted that it becomes, for one of the key substitutes

1 in some sense, for reinsurance. It's also there's a  
2 potential, an intended effect on risk selection.

3           And the work that we've done thus far, I think,  
4 does provide a framework for LIS versus non-LIS, in  
5 particular in terms of adequacy. I think we could do -- it  
6 would help to do a little bit more work in there, I think,  
7 looking at sort of predictability of the model and  
8 predictive power of the models in terms of model  
9 performance, as well as looking at residuals.

10           I think we looked at variability, in some sense,  
11 but one of the pieces that I was concerned about is some of  
12 the lack of variability on the LIS side could be driven by  
13 the cost-share, or lack of cost-sharing differentials. And  
14 so that could actually potentially play into that, so we  
15 might want to take a little bit more look at the risk  
16 adjustment piece, just given how much more important I  
17 think it's going to end up being in this kind of structure.

18           The second piece that I was curious to focus a  
19 little bit more attention on is the premiums. If we take a  
20 step back and think about what insurance is really supposed  
21 to be about, it's supposed to be about protecting really  
22 large expenditures that usually are unanticipated. Part D

1 is not exactly purely insurance in that sense, economically  
2 speaking, but it should probably have some feature that  
3 around that.

4           And so the part that concerns me is around  
5 premiums and premium growth, and I think if we anticipate  
6 that plans are going to take on more liability, the natural  
7 expectation should be that premiums will probably grow.  
8 And I think, Rachel, your point that if overall the size of  
9 this pie is growing over time because drug prices are going  
10 up and drug volume is going up that the cost-sharing  
11 component in the aggregate sense should also grow for the  
12 beneficiary I think certainly resonates. But whether that  
13 gets allocated into premium versus into conditional on  
14 participation cost-sharing is a question I think we should  
15 actually have a point of view on.

16           And I will say that you've come up with quite an  
17 elegant design, because I've tried to think through other  
18 ways that we could try to protect premium growth and I  
19 haven't come up with anything better. But I think it's  
20 worth noting that we should think about how premiums grow  
21 and if we want to set, particularly in the context of a  
22 standard formulary for going in that direction, it may be

1 good to think about what kind of protections we want to put  
2 on the premium growth side of things.

3           And a related point is something that exists in  
4 other parts of the Medicare program, particularly in Part B  
5 premiums, is they are sort of income-rated or adjusted for  
6 income as well. It's an element that we haven't introduced  
7 here at all. It may have been considered in the past, but  
8 I was curious about the Commissioners' appetite to consider  
9 something like an out-of-pocket adjustment based on income  
10 level, and/or premium adjustment based on -- or some sort  
11 of subsidy that's --

12           MR. ROLLINS: At least in terms of the premiums  
13 the income adjustment that you describe in Part B is also  
14 part of Part D as well.

15           DR. NAVATHE: But not on the -- but we haven't  
16 considered that on the out-of-pocket side. So that's the  
17 thought here.

18           And then the last part was just, I won't actually  
19 get into the details of it, but just echoing this support  
20 for perhaps differentially generous risk corridors for  
21 plans that have a disproportionate amount of LIS benes.

22           DR. CROSSON: So just to bring those two ideas

1 together, are you thinking about, for example, you know, an  
2 income-related exception, if you want to call it that, for  
3 the beneficiary exposure in the coverage gap? For example,  
4 so you have --

5 DR. NAVATHE: In the catastrophic phase?

6 DR. CROSSON: -- you have a catastrophic absolute  
7 cap for some individuals but then other individuals could  
8 be required?

9 DR. NAVATHE: Or if we end up deciding -- I guess  
10 my thinking would be if we end up with some sort of cost-  
11 sharing element in the catastrophic phase then it may or  
12 may not be necessary. But if we don't, then we may want to  
13 think about the out-of-pocket maximum to be income-rated,  
14 effectively. That's the thought I had.

15 DR. CROSSON: Okay. Thanks.

16 DR. DeBUSK: The one question, this issue of  
17 cost-sharing in the catastrophic phase -- and help me  
18 because I may be off on this -- but in MAPDs you don't have  
19 that issue, right? I mean, they have the out-of-pocket  
20 limit. So one-third of the beneficiaries are off the table  
21 to start with. Of the fee-for-service beneficiaries that  
22 are left, are there med sup? Oh, that's right. It's not a

1 full -- I know. I know. My math is off.

2 DR. SCHMIDT: No, no. It's just that the hard  
3 cap for MA plans is with the A and B benefits, not the D  
4 benefits.

5 DR. DeBUSK: So D does still have the cost-  
6 sharing.

7 DR. SCHMIDT: Right.

8 DR. DeBUSK: Are there any med sup plans that  
9 have catastrophic cost-sharing relief?

10 DR. SCHMIDT: So you can't have D sups. I mean,  
11 you can't have Medigaps with really relationship to Part D.

12 DR. DeBUSK: Anymore. I think MACRA -- was it  
13 MACRA that wiped that out.

14 DR. SCHMIDT: Yeah. That was at the beginning of  
15 the program.

16 DR. DeBUSK: Okay. Okay. So we truly are, I  
17 mean, everyone is exposed to this 5 percent. Okay. Thank  
18 you. Thanks for clearing that up.

19 DR. CROSSON: Okay. We have Larry, Kathy, and  
20 Bruce.

21 DR. CASALINO: Yeah. One thing we haven't  
22 discussed very much is the consolidation of unintended



1 consequence, which came up towards the end of the last  
2 meeting, I think. I'm all for putting more risk on the  
3 plans, but the concern was -- and I think that staff had  
4 worked to address it -- that putting a lot more risk on the  
5 plans would make it more likely that smaller plans and  
6 possibly, especially small plans that serve a lot of LIS  
7 beneficiaries, would not be able to survive and would be  
8 absorbed by some of the big national plans that can more  
9 easily -- don't have to worry about reinsurance, really,  
10 costs. And we haven't discussed it much.

11           I think the staff tried to come up with risk  
12 corridors in a transition period as a way of helping with  
13 this problem, and this has been casually mentioned a couple  
14 of times as kind of the solution.

15           So I'm just curious if people who live in this  
16 world and/or know more about it than I do, is there a sense  
17 that having a -- I mean, after the transition period -- a  
18 transition period is a transition period -- the small plans  
19 are not going to be any bigger, probably, at the end of the  
20 transition period. So does a transition period merely  
21 delay what at least some of us think is an undesirable  
22 unintended consequence? And if that's all it does, we

1 should at least acknowledge that and not talk about a  
2 transition period and risk corridors during that transition  
3 period as an actual prevention of unintended consequences.

4           So I'm just curious. You know, Pat, Jaewon,  
5 others who really care and know about this, have we found  
6 the solution to the problem that we all want to put more  
7 risk on the plans but we don't necessarily want more  
8 consolidation?

9           DR. PAUL GINSBURG: Actually, Larry, before you  
10 go to them, I want to say that what makes a transition  
11 valuable rather than just postponing pain, is the fact that  
12 there's great uncertainty when you change the whole design  
13 for a plan, and it means that -- and they have to set a  
14 premium. So at least this means that by the time they have  
15 to set a premium with this new system they have a few years  
16 of experience under this regime and they can -- in a sense,  
17 there's much less uncertainty for them going forward.

18           DR. CASALINO: I can see how that would really  
19 help in the short run, but in the long run it might not  
20 alter the fundamental dynamic, I think. But that's what  
21 I'm curious to hear about from other people.

22           DR. CROSSON: Pat, would you like to comment, or

1 Jaewon?

2 MS. WANG: Just to start off, I think that we --  
3 you know, the risk corridor proposal is very, very much  
4 appreciated. I'm not exactly sure how that looks when you  
5 actually get there. And don't forget that even at 2.5  
6 percent, you know, you're still losing up to that amount of  
7 money, and I think it could put pressure. So it's just a  
8 concern. I don't know what the ultimate solution is.

9 But one of the reasons that I have continued to  
10 say let's consider potentially different benefit structure  
11 for LIS is that the exposure there is bigger. I mean, the  
12 chapter now sort of says there have to be additional tools  
13 given to the plans to manage this, and I think everything  
14 that was listed is critically important. But just even the  
15 size of the spend, even if you narrow the risk corridor to  
16 2.5 percent, it's a lot more money that a plan faces to  
17 lose. And that's why given the characteristics of the  
18 population, there is still difficulty managing it, because  
19 you don't have full control over copays. A very good  
20 proportion of the population is zero. So, you know, and  
21 these are the dual eligibles who are nursing home eligible,  
22 who are in all the dual demos. I mean, there's not much

1 you're going to do to try to influence beneficiary behavior  
2 there.

3 I think that in the reinsurance layer there  
4 should be a higher share from both Medicare as well as  
5 manufacturers, in terms of absorbing the responsibility for  
6 the population. So, you know, to Warner's point about  
7 what's the magic about, you know, a certain percentage, I  
8 asked the questions about what's the 35 percent considering  
9 the elimination of the LICs in the coverage gap, what would  
10 that actually be for plans? Like a D-SNP sort of thing,  
11 LIS members.

12 So that's why I continued to suggest that it  
13 would be important to have more parties with skin in the  
14 game in the reinsurance layer, just to address the fear  
15 that the dollars are big, and at least for plans that are  
16 community plans, the exposure is great. I think that  
17 that's part of the solution, that Medicare should absorb  
18 more and manufacturers should absorb more, even a third, a  
19 third, a third, or whatever it is. Just bigger than the  
20 plan design that's being considered for non-LIS.

21 DR. CROSSON: Right. And I would add that, you  
22 know, as the staff has presented this revised package, it's

1 not the thesis that the risk corridor adjustments for a  
2 temporary period of time is the entire solution to this  
3 assumption of risk. But in addition, as Pat has  
4 maintained, and others, you know, creating more robust  
5 tools for the plans to manage the risk is an important part  
6 of this.

7           And I would say, as we go into March and April,  
8 we may want to hedge on putting some hard numbers down, as  
9 we've talked about. I would go in the opposite direction  
10 in terms of the specificity that we have in the  
11 recommendation for the improvement in plan capabilities,  
12 because I think that's an important part.

13           Okay. Kathy.

14           MS. BUTO: So, Larry, were you finished?

15           DR. CASALINO: Yeah.

16           DR. CROSSON: Oh, I'm sorry.

17           DR. CASALINO: You probably -- no, it was good  
18 intuition. No, just very briefly, I think -- so my six  
19 months on the Commission have made me feel a lot dumber,  
20 and two things in particular have made me feel dumber. One  
21 is talking to  
22 Brian in detail about anything pretty much.

1 [Laughter.]

2 DR. CASALINO: I suspect I may not be the only  
3 one. But the other is Part D, and so it really is a  
4 magnificent achievement what you guys have done. I think  
5 the package is really excellent.

6 I just didn't want us to -- the transition and  
7 the risk corridors have been mentioned a couple of times as  
8 if they solve the problem, and I don't think they fully do.  
9 It may not be possible to resolve the problem and I  
10 appreciate that it may be more important to have this  
11 package than to fully resolve this problem. But I just  
12 didn't want us to assume that it had been solved.

13 DR. CROSSON: By the way, your experience coming  
14 on the Commission is universal. And for some of us it  
15 never goes away.

16 MS. BUTO: Okay. So my --

17 DR. CROSSON: I'm sorry. Kathy, go ahead.

18 MS. BUTO: So I have to say I think I have  
19 thought, since you first proposed this, this is a brilliant  
20 restructuring of Part D, and I just want to commend you on  
21 it. It's a joy to see the donut hole go away. It's really  
22 a joy to see a greater alignment in the benefit in a way

1 that I think had the money been there in the initial go-  
2 around they would have designed it something like this.  
3 They created the donut hole to make up for a funding  
4 shortfall.

5           I'm very concerned about the LIS population and  
6 plans that concentrate on that population. I think that,  
7 from what I can tell from reading the chapter, the  
8 combination of the risk adjustment, the risk corridors, and  
9 additional tiers and copays goes a long way to helping  
10 plans gain better traction on that population. But I don't  
11 feel as if that -- back to Larry's point -- that is  
12 something that is really going to approach their ability to  
13 manage the benefit for other beneficiaries.

14           So then I looked at the catastrophic phase, and I  
15 wondered whether -- and this is sort of along the lines  
16 that Pat was getting at -- whether there was -- we ought to  
17 consider having reduced plan liability for high-LIS-  
18 concentrated plans, having a lower percentage of risk in  
19 the catastrophic phase and then have the delta of that  
20 redistributed among manufacturers and Medicare.

21           Just something to think about. I recognize that  
22 for this go-around you may not want to do that, but I

1 thought, at a minimum, we ought to acknowledge that this is  
2 a potential area of concern, that there still aren't enough  
3 tools necessarily to help plans with high drug spend in the  
4 catastrophic phase, and sort of endless drug spend for that  
5 population.

6           I think we may want to consider -- again, I know  
7 it's not as neat -- but retaining, I think as Larry was  
8 getting at and Amol, the narrower risk corridors for the  
9 LIS-heavy plans, whether it's D-SNPs or some other  
10 category. But even if we transition out of that for other  
11 plans that we look at retaining it to give them more  
12 leverage or less risk in the pre-catastrophic phase.

13           So again, just for LIS plans, have a narrow risk  
14 corridor that continues. And wherever we can find tools  
15 that will help them, that would be helpful.

16           Back to Dana's point about the potential  
17 increases in plan premiums, if plans are not successful in  
18 managing spend for the LIS population and it continues to  
19 be disproportionate, that's going to raise premiums for  
20 everybody. So I think there is a spillover effect to all  
21 plans that we need to be concerned about.

22           So I think at least for this go-round, maybe an



1 acknowledgment that this is an area of concern and that  
2 there may be tools we need to consider going forward,  
3 whether it's separate plan risk percentage above the cap,  
4 whether it's sustained narrower risk corridors below the  
5 cap, other tools, just a way of saying we know this is not,  
6 you know, sort of the end of it, I think that would be  
7 helpful because I do worry that there are some unintended  
8 consequences here for those plans.

9           And, lastly on the issue of pricing by  
10 manufacturers, I think the discounts above the cap will  
11 make a big difference. It may influence behavior  
12 downstream. I think it will have the, unintended or  
13 otherwise, consequence of higher launch prices, because if  
14 you're going to demand discounts into infinity, I think  
15 that's what's going to happen, and particularly as we look  
16 at capping the increases in prices, I think that's going to  
17 lead to higher not lower launch prices.

18           DR. NAVATHE: Kathy, on that point that's where  
19 the idea of an inflationary cap may actually help, however.

20           MS. BUTO: But only after [off microphone].

21           DR. CROSSON: Okay, thank you. And we're --  
22 Bruce is going to wrap it up for us.

1           MR. PYENSON: Thank you very much. Having done  
2 some modeling on similar proposals, I'm actually  
3 comfortable with the particulars that you've offered here,  
4 as well as the risk issues overall, though I'd like to  
5 characterize the risk issues as of different importance for  
6 MA-PD LIS versus freestanding small PDPs. In particular,  
7 the consolidation of the industry means there's only a few  
8 back offices throughout the entire industry, no matter what  
9 the name of the PDP is or MA-PD, but it's a different issue  
10 for MA-PDs and I think more important.

11           I've got a few thoughts on the tactical issues, a  
12 thought on DIR, which Brian mentioned, or the rebates, and  
13 an income-based cost-sharing concept, and, finally, a risk  
14 and behavioral comment.

15           On the tactical side, I think there's a lot of  
16 particular things that could be done to help manage -- that  
17 would help Part D plans manage risk and, in particular, the  
18 LIS plan. I'd like to point out a few of them. One is in  
19 the complaint tracking module and the appeals process.  
20 We've mentioned that in the past, but I think that's a very  
21 important issue for management of drugs. And if we're  
22 going to do utilization management, it can't all be trumped

1 through the risk of complaints in the way it might be  
2 today.

3 I think there's a need for mandatory generics, a  
4 federal preemption of DAW, and an openness to mail order.  
5 These are very, very common throughout commercial insurance  
6 and other forms of insurance, so easing the rules on that  
7 for Medicare could be really valuable.

8 And, finally, the risk adjustment, moving to  
9 using two years of encounter data, the value of that I see  
10 is in minimizing the value of risk score optimization and  
11 the differentials that large MA-PDs might have versus the  
12 regional and smaller ones. So I think that would be an  
13 important tactic to help make the whole package work.

14 On the DIR side, although the catastrophic share,  
15 fixing that will have a very beneficial effect, it doesn't  
16 take away the potential for blocking an anticompetitive  
17 behavior, but I think some other rules could. For example,  
18 the rules that would not allow blocking of generics or  
19 lower-cost biosimilars, I think those are things that are  
20 tactical and could be beneficial for the kinds of  
21 behavioral changes that we want, we all agree with.

22 I really do like Amol's income-based cost

1 sharing. I think the structure of that for catastrophic  
2 could be relatively simple if the data's available. That's  
3 done today kind of on premium, but there's a couple of  
4 grades of low-income subsidy on the premium side.

5           Finally, I think the behavioral issues that we  
6 hope for on the plan side would induce lower costs to the  
7 beneficiaries and lower costs to the federal government,  
8 and that's the goal, but I think it would be helpful to  
9 think about what -- and maybe to be explicit, what  
10 behaviors in Part D we actually would like to encourage on  
11 the part of the plans. So in particular, we would, I  
12 think, like plans to have behaviors that would lead to low  
13 premium rates, perhaps not the member premium increasing  
14 but stabilizing or even going down, or other costs going  
15 down. But I think we can -- obviously, the plans are going  
16 to try to make money, and there's probably other ways they  
17 can make money, for example, the vertical integration with  
18 pharmacies, and that's what a mail-order pharmacy is, could  
19 lead to other sources of revenue. So I think being a  
20 little explicit about what the behavior changes could be  
21 here would be a helpful addition to the chapter.

22           I know that's a long list. There's nothing

1 fundamental that I disagree with. I think the work is  
2 terrific, so thank you very much.

3 DR. CROSSON: Okay. Thank you, Bruce.

4 I just want to reiterate what a number of people  
5 have said, which is, first of all, this is outstanding work  
6 in its original conceptualization and in the flexibility  
7 that you've had to bring it to this point, taking into  
8 consideration points that have been made by the  
9 Commissioners in previous meetings.

10 I also think that equal to its importance and the  
11 quality of the work is the complexity of it, and to go back  
12 to Larry's point, you know, there was a period of time  
13 where just the conceptualization of the doughnut hole and  
14 trying to understand it gave me this mental image of  
15 falling into a pit because of the complexity of trying to  
16 understand not only how it worked and the ramifications of  
17 it, but potentially how to change it. And I think you've  
18 led us forward in an excellent manner there, and I think  
19 it's going to be in the benefit not only to the Medicare  
20 program but I think by and large to at least a number of  
21 beneficiaries who have now experienced really extraordinary  
22 financial risk. So thank you for this work, and we'll come

1 back again in March.

2 [Pause.]

3 DR. CROSSON: Okay. We had a somewhat prolonged  
4 first session, and so we've had a few Commissioners who had  
5 to take a short break here, but I don't want to get too far  
6 behind. And I apologize to our guests because the first  
7 presentation and discussion went longer than was scheduled.

8 Today we're going to take on once again the  
9 question of redesigning the Medicare Advantage quality  
10 bonus program, and we've got Ledia, Andy, and Carlos here  
11 to take us through this work.

12 MS. TABOR: Great. Good morning. We are here to  
13 continue the discussion of the redesigned value incentive  
14 program for MA, which was initially published in the past  
15 June report to the Congress and recently discussed at the  
16 November Commission meeting.

17 The redesigned MA value incentive program  
18 addresses the flaws in the current quality bonus program.  
19 Before moving on, we would like to acknowledge Sam Bickel-  
20 Barlow, who has been instrumental in the modeling work we  
21 present today.

22 Reforming the current quality bonus program is a

1 matter of urgency. One-third of Medicare beneficiaries are  
2 now enrolled in Medicare Advantage, and that number is  
3 growing. MA plans are also viewed as having the potential  
4 to be more efficient than fee-for-service while providing  
5 high-quality care. However, the Medicare program does not  
6 have the tools to judge the quality of care MA plans  
7 provide, and beneficiaries do not receive accurate  
8 information about their options.

9           In the QBP, 82 percent of enrollees are in MA  
10 plans currently classified as a high-quality plan,  
11 entitling them to Medicare Trust Fund and taxpayer-financed  
12 extra payments. Unlike the quality incentive programs for  
13 fee-for-service Medicare, which are budget neutral or  
14 produce savings, the QBP adds \$6 billion per year in  
15 program costs or a potential \$94 billion over 10-year  
16 savings as estimated by CBO.

17           In addition to the concerns over the QBP being a  
18 rewards-only program, the Commission has long discussed the  
19 flaws of the QBP, presented on the left-hand side of this  
20 slide. I will not go over them, but they are here for your  
21 reference.

22           The redesigned MA value incentive program will

1 meet five key elements of design presented on the right-  
2 hand side of the slide, which I'll walk through over the  
3 coming slides. Then Andy and Carlos will walk through  
4 modeling results of an illustrative MA value incentive  
5 program that incorporates these five design elements.

6           The MA-VIP scores a small set of population-based  
7 measures that focus on patient outcomes and experience.  
8 Using a small set of measures is simpler to administer for  
9 both the Medicare program and for MA plans than the current  
10 QBP with a set of 45 measures.

11           In November, the Commission discussed the  
12 importance of including a small number of prevention and  
13 chronic care management measures that are tied to clinical  
14 outcomes. This table displays an illustrative MA-VIP  
15 measure set that incorporates the Commission's discussion.  
16 This is not intended to be a definitive list of measures,  
17 and CMS should develop the MA-VIP measure set through a  
18 public review and input process. We anticipate that the  
19 MA-VIP measure set would continue to evolve as better data  
20 becomes available.

21           In our illustrative modeling of the MA-VIP, we  
22 scored the six measures that are noted with an asterisk.



1 Because plans currently collect and report quality results  
2 at the contract level and not at the market area level, we  
3 could only use measures where we had beneficiary level  
4 encounter or survey data that we could reassign to a plan  
5 within a market area to calculate a quality score. When  
6 the MA-VIP is implemented, CMS would be able to score a  
7 full set of measures based on plan level quality  
8 information collected at the market level.

9           The MA-VIP evaluates quality at the local market  
10 level, meaning it scores a plan's performance for the  
11 beneficiaries they cover in a local market area. The  
12 Commission has long discussed that the QBP's use of  
13 contract level results is too broad and inconsistent  
14 because contracts span noncontiguous geographic areas.

15           Using market level measure results gives a more  
16 accurate picture of quality for beneficiaries who are  
17 selecting a plan where they live and also for the Medicare  
18 program to understand plan performance. Under the  
19 illustrative MA-VIP modeling results that we'll present  
20 today, our reporting unit is a parent organization within a  
21 MedPAC market area that had sufficient enrollment to  
22 reliably calculate measure results.

1           The Commission's hospital value incentive program  
2 distributed rewards and penalties nationally, meaning a  
3 pool of dollars was distributed to hospitals based on their  
4 quality performance, regardless of the hospital's location.  
5 However, the MA-VIP uses a different approach, because the  
6 Commission has discussed that MA plans should be evaluated  
7 at the local area, which also leads to distributing rewards  
8 and penalties at the local area. This market level  
9 approach also makes sense because, unlike hospitals, plans  
10 change where they offer coverage each year, making it  
11 possible to enter more profitable market areas and leave  
12 less profitable market areas each year.

13           A national approach could have an unintended  
14 consequence of creating MA deserts because plans may move  
15 out of low-quality areas where they would not receive  
16 quality rewards. However, a trade-off with the market  
17 approach is that plans with low quality compared to the  
18 national average may receive rewards.

19           A benefit of the local market approach is that  
20 the best choices available to beneficiaries considering  
21 enrollment in MA in a given market will be the plans  
22 receiving rewards.

1 Medicare should take into account as necessary  
2 differences in enrollee populations, including social risk  
3 factors. One way to do this is to stratify plan enrollment  
4 into groups of beneficiaries with similar social risk  
5 factors to determine payment adjustment. Comparing groups  
6 with similar patient composition accounts for social risk  
7 factors without masking disparities and plan performance,  
8 as would be the case if measure results themselves were  
9 adjusted.

10 In our illustrative MA-VIP modeling, we  
11 stratified each parent organization's enrollment into two  
12 peer groups and then calculated measure results for each of  
13 the groups. We use eligibility for full Medicaid benefits  
14 as a proxy for social risk factors because it's a readily  
15 available data source and it captures a characteristic that  
16 may make a plan's enrollees more difficult to treat.  
17 Policymakers could continue to explore other factors that  
18 could be used in the peer grouping.

19 The MA-VIP uses a performance-to-points scale for  
20 each measure to convert a plan's result to a score, which  
21 determines the rewards and penalties the plan receives.  
22 There are two key features of this scoring mechanism.

1           First, plans know the performance scale before  
2 the performance year, which can drive quality improvement  
3 because plans will be able to see how they will be rewarded  
4 for improvements in performance on each measure. And the  
5 current QBP plans do not know the targets that will be used  
6 ahead of time.

7           Second, the MA-VIP scale is continuous, meaning  
8 that every change in performance will affect the number of  
9 points achieved and the size of any reward or penalty.  
10 There are no performance cliffs like the QBP.

11           Ideally, MA plans would also know the payment  
12 multiplier or percentage adjustment to payment per point  
13 that converts their quality score to a payment adjustment.  
14 Because the MA-VIP is rewarding quality within local market  
15 areas, it would be complex and potentially unreliable to  
16 prospectively estimate each market's payment multipliers  
17 since plan participation, performance, and payments are  
18 less predictable at the market level.

19           However, a couple of years after MA-VIP  
20 implementation, plans may have a general sense of how much  
21 of a reward they can receive for improved performance. In  
22 our illustrative modeling, we set each measure scale based

1 on a beta distribution of current national performance.  
2 Policymakers can consider other methods to set the  
3 performance scale.

4 I'll now turn it over to Andy to discuss modeling  
5 results.

6 DR. JOHNSON: Our modeling relied on claims and  
7 survey data for various measures. The scope of our  
8 modeling was limited by the availability of survey data,  
9 which are collected at the contract level, not at the  
10 market-area level.

11 We assigned available survey data to a parent  
12 organizations and a market area and limited our analysis to  
13 market areas with at least three parent organizations  
14 having sufficient data. Requiring a minimum of three  
15 parent organizations per market prevents the direct  
16 transfer of reward dollars from one parent organization to  
17 another if only two organizations are present.

18 We were able to include 78 unique parent  
19 organizations in 61 market areas for a combined total of  
20 258 reporting units in our modeling. These reporting units  
21 represent 39 percent of MA enrollment.

22 When implementing the value incentive program,

1 survey collection requirements would change to eliminate  
2 the data limitation we faced, and the program would cover  
3 about 89 percent of MA enrollment.

4 Over the next few slides, I will review our  
5 modeling results, first by showing point distributions in a  
6 few example markets and then by showing the distribution of  
7 rewards and penalties which are applied as payment  
8 adjustments that increase or decrease overall plan  
9 payments.

10 In this example, we look at how the MA value  
11 incentive program would distribute rewards and penalties  
12 using a national distribution. This is the same method  
13 used in the hospital value incentive program.

14 This figure shows the results for parent  
15 organizations in three example markets for the non-full  
16 dual-eligible peer group.

17 In Market 2, the middle column, there were seven  
18 parent organizations represented by the seven circles. The  
19 size of each circle is proportional to the enrollment in  
20 that parent organization. The center point of each circle  
21 is aligned the number of points achieved, according to the  
22 scale on the left of the figure. The top parent

1 organization in Market 2 achieved about 7.3 points, and the  
2 bottom achieved about 4.5 points.

3           With national distribution, a single reward or  
4 penalty threshold is applied to all markets, shown by the  
5 line. Parent organizations in green above the line  
6 received a reward, and those in red below the line received  
7 a penalty. The size of any reward or penalty increases as  
8 the number of points achieved gets farther from the line.

9           One consequence of national distribution is that  
10 for some markets, all parent organizations will receive a  
11 penalty, as in Market 1, and all parent organizations will  
12 receive a reward, as in Market 3. About 30 percent of  
13 markets in our modeling offered only rewards or only  
14 penalties to all parent organizations in their market.

15           This figure shows market-level distribution of  
16 rewards and penalties for the same markets as the previous  
17 slide. The main difference is that the parent  
18 organizations performing above average in their market  
19 receive a reward, and those performing below average in  
20 their market receive a penalty. As you can see by the  
21 three lines, average performance varies across markets, and  
22 there is a different reward or penalty threshold in each

1 market.

2           Because the value incentive program uses a  
3 national points scale, shown on the left of the figure,  
4 beneficiaries can compare the quality of plan options in  
5 their market with MA plan options and MA plan quality  
6 across the country.

7           The two main reasons for using market-level  
8 distribution in the MA value incentive program modeling  
9 are, one, the ability of plans to leave and join markets in  
10 each year and, two, the fact that MA enrollees are limited  
11 to plan choices in their market.

12           Local distribution of rewards avoids persistently  
13 penalizing market areas with lower performance relative to  
14 the national average. The remainder of results we will  
15 present today as based on a local distribution of rewards  
16 and penalties.

17           This figure shows the range of payment  
18 adjustments for the 258 reporting units and the frequency  
19 of each size adjustment. The black bars show the results  
20 for fully dual eligible peer group, and the white bars show  
21 results for the peer group containing all other enrollees.

22           The results of our modeling show that payment



1 adjustments tend to be small for individual parent  
2 organizations in a single market. Our modeling used a  
3 reward pool funded with 2 percent of total MA payments, and  
4 we found a range of payment adjustments from 1.5 percent  
5 penalty to a 1.5 percent reward. However, nearly 80  
6 percent of all payment adjustments were between a 0.5  
7 percent penalty and a 0.5 percent reward.

8           If the size of these payment adjustments was  
9 deemed too small, policymakers could increase their  
10 magnitude in two ways. First, the performance to points  
11 scale could be modified so that points achieved were  
12 distributed more widely between zero and 10 points. And  
13 second, the size of the reward pool could be increased.  
14 For example, if the reward pool were increased from 2  
15 percent of MA payments to 4 percent, the magnitude of each  
16 payment adjustment in this figure would double.

17           This figure shows the payment adjustments from  
18 the previous slide aggregated to each parent organization.  
19 Of the 78 parent organizations in our sample, 76 had an  
20 aggregate payment adjustment between a 0.6 percent penalty  
21 and a 0.6 percent reward. The red bars show parent  
22 organizations that operated in five or more markets, which

1 collectively account for the majority of observations in  
2 our modeling.

3           None of these larger parent organizations  
4 exclusively received rewards or penalties in all markets in  
5 which they operate. Instead, they received rewards in some  
6 markets, offset by penalties in others, and so their  
7 aggregate payment adjustments tended to be small.

8           Now I will turn it over to Carlos to discuss  
9 comparison with the QBP.

10           MR. ZARABOZO: This slide highlights the major  
11 findings of our comparison of the MA-VIP to the current QBP  
12 for the markets that we could analyze.

13           From the plan perspective, there are differences  
14 between which plans are in bonus status in the QBP versus  
15 those that have net positive payment adjustments in the MA-  
16 VIP. Plans enrolling large shares of duals fare better  
17 under the MA-VIP, and large organizations that had an  
18 advantage in the QBP system have less of an advantage in  
19 the MA-VIP.

20           From the beneficiary perspective, if plans have  
21 lower revenue from Medicare, there can be a reduction in  
22 extra benefits for MA enrollees, but in relation to the

1 current record-high level of extra benefits, the reduction  
2 is of limited magnitude.

3           The MA-VIP proposed design stratifies results for  
4 two populations, the full duals and all others, comparing  
5 results for each population at the market level. Our  
6 modeling found that this approach narrows the disparities  
7 in financial performance between dual populations and  
8 others.

9           In this slide, the first two sets of bars  
10 illustrate that in the QBP, a little over half of full  
11 duals were in bonus-level plans in 2017, the solid blue bar  
12 at 54 percent for full duals in the QBP results, as  
13 compared to the 82 percent in the solid blue bar for non-  
14 duals in the QBP. This large difference is narrowed in the  
15 MA-VIP. For full dual eligible beneficiaries, 53 percent  
16 are in plans with positive net payment adjustments in the  
17 MA-VIP, compared to a similar share, 57 percent, for non-  
18 duals.

19           The last two pairs of bars show that employer  
20 group- or union-sponsored MA plans continue to fare better  
21 than plans for other populations, while the under-65  
22 beneficiaries, those entitled to Medicare on the basis of

1 disability, fare worse than other populations. This may  
2 argue for additional adjustments in payments or more  
3 stratification in a MA-VIP system.

4           Looking at results at the level of the parent  
5 organization for markets we could analyze, about half of  
6 organizations, 40 out of 78, have a positive net payment  
7 adjustment in the MA-VIP. Even though there was  
8 essentially a half-and-half split in the number of  
9 organizations with net positive results and net negative  
10 results, 40 and 38, the enrollment distribution was  
11 different.

12           As shown in the second column of numbers, a much  
13 larger share of the enrollment, 62 percent, was in  
14 organizations with a negative net payment adjustment.

15           Looking at the next column, you see that  
16 organizations with negative net payment adjustments have an  
17 average enrollment of 113,000 enrollees compared to 66,000  
18 for organizations with a positive net payment adjustment.

19           These data show that the MA-VIP is less likely to  
20 favor larger organizations, which are the organizations  
21 that have benefitted from contract consolidations in the  
22 QBP and are also more likely to be the organizations with

1 high shares of employer-group enrollees.

2           In the 2020 star ratings, for example, there is a  
3 greater-than-10-percentage-point difference between the  
4 bonus status among enrollees of the 10 largest  
5 organizations, with 85 percent of enrollees in bonus  
6 status, and all other organizations, where 73 percent of  
7 enrollees are in bonus status.

8           There are some very clear differences in how  
9 organizations fare under the MA-VIP versus the QBP. In our  
10 data, there were 20 parent organizations not in bonus  
11 status under the QBP. In the MA-VIP, however, eight of  
12 these organizations have positive net payment adjustments.  
13 These organizations are all what are known as regional  
14 plans; that is, plans that operate in single markets or  
15 limited geographic areas.

16           Making the MA-VIP a budget-neutral system would  
17 achieve substantial program savings, \$94 billion over 10  
18 years as estimated by the Congressional Budget Office. The  
19 current QBP is financed by added program dollars of about  
20 \$6 billion per year, or an average of about \$24 per member  
21 per month for plans in bonus status.

22           Plans are not required to use such extra revenue

1 to finance extra benefits, but if they did, \$24 would be  
2 the theoretical maximum amount by which extra benefits  
3 would decline in a budget-neutral system, and if plans  
4 chose not to reduce extra benefits at all and instead  
5 reduce profits, administrative costs, or health care costs,  
6 the theoretical minimum reduction in extra benefits would  
7 be zero.

8           However, our past analyses of bidding behavior  
9 included in the June 2019 report suggests that the  
10 reduction in extra benefits would be from about \$6 to \$17  
11 per member per month. In the context of the record-high  
12 level of extra benefits, this would mean that extra  
13 benefits would decline from a year 2020 average of \$121 per  
14 member per month to about \$104 to \$115 per member per  
15 month, close to the 2019 level of \$107.

16           Turning now to policy options, the policy option  
17 we have been working toward would replace the current MA  
18 quality bonus program with a value incentive program based  
19 on the five design elements that we have discussed over the  
20 past two years.

21           It would score a set of outcomes-based measures,  
22 evaluate quality at the local level, account for social

1 risk factors using stratification into peer groups, and  
2 establish a system for predictably distributing rewards and  
3 penalties with no cliff effects on a budget-neutral basis.

4           The MA value incentive program could be phased  
5 in. For example, there could be a phase-in period with two  
6 transition years. The first transition year would bring  
7 the QBP rewards closer to budget neutrality by reducing the  
8 size of any bonuses by half. Benchmark increases of 5 and  
9 10 percent would be reduced to 2.5 and 5 percent during  
10 this year.

11           In the second transition year, MA-VIP scoring  
12 would be used to determine any rewards and penalties, but  
13 the size of rewards and penalties would be half of their  
14 full size. For example, if in a fully phased in MA-VIP,  
15 the rewards and penalties are funded with 2 percent of plan  
16 payments, then in the MA-VIP transition year, the funding  
17 would be based on 1 percent of plan payments rather than 2  
18 percent.

19           As Ledia discussed at the start of the  
20 presentation, we are unable to assess MA quality in a  
21 meaningful way, and beneficiaries lack good information  
22 about MA quality in their market area. Yet the quality

1 bonus program generates additional nonbudget-neutral  
2 spending that costs the Medicare program about \$6 billion  
3 annually.

4           Our modeling demonstrates the feasibility of the  
5 MA-VIP design and shows how the five aspects described in  
6 the policy option offer an improvement of over the current  
7 QBP.

8           In March, we plan to return with a Chairman's  
9 draft recommendation to replace the QBP with the MA value  
10 incentive program. We would like your feedback on the  
11 aspects of the MA value incentive program that we presented  
12 today as well as considerations for describing the program  
13 in the chapter that we are working on to support the  
14 development of a recommendation.

15           Thank you, and we'll now turn it back to Jay.  
16 And in view of the time, I think we do not have time for  
17 questions or comments.

18           [Laughter.]

19           DR. CROSSON: Good luck with that.

20           So I just have a clarification myself, and I  
21 think you know what this is going to be, Carlos. Could you  
22 turn to Slide 12?



1           Right. So I just wanted to ask you to point out  
2 that this range of payment adjustments here across the  
3 distribution is in addition, as I understand it, to the  
4 return of the 2 percent withhold. So these are net  
5 numbers. Is that correct?

6           MR. ZARABOZO: That's correct. They're net.

7           DR. CASALINO: Say that again?

8           DR. CROSSON: So where you have this range at the  
9 bottom of minus 1.5 to plus 1.5, that's net of the return  
10 of the 2 percent withhold to all the plans?

11          MR. ZARABOZO: 2 percent back plus --

12          DR. CROSSON: Yes, yes.

13          MR. ZARABOZO: -- 1.5 percent.

14          DR. CROSSON: Yes.

15          MR. ZARABOZO: Okay. At least to me, I didn't  
16 think that was clear, actually.

17          DR. DeBUSK: If it's zero, then would it consider  
18 that you get your money back, or it's zero for your 2  
19 percent?

20          MR. ZARABOZO: Zero is you get your money back.

21          DR. DeBUSK: Okay.

22          DR. CROSSON: Right, right, right. Okay. Got

1 that? Okay. All right. Thanks.

2 Clarifying questions? I'm going to take a break  
3 for a second.

4 DR. PAUL GINSBURG: Yeah. Okay. Marge and Dana.  
5 Pat and Jon.

6 MS. MARJORIE GINSBURG: This is a great report.

7 DR. PAUL GINSBURG: And Jaewon.

8 MS. MARJORIE GINSBURG: I jumped the gun. Am I  
9 jumping the gun, or am I on? Okay. I think I'm on.

10 Anyway, wonderful report. In my view, this is  
11 one of the most important topics that the Commission has to  
12 deal with in the coming year. So it's very exciting.

13 I have a number of questions. I'm going to try  
14 to keep them smaller.

15 On page 24 of the report -- let me find it -- in  
16 the middle section, it says the parent organization with  
17 the highest quality score in the market will receive the  
18 greatest reward. The organization with the lowest score  
19 will receive the greatest penalty.

20 What if the scores are really, really, really  
21 close? How do we -- I mean, that's a pretty dramatic  
22 difference between reward and penalty for something that

1 may be a very, very small score.

2 DR. JOHNSON: It still would be the case that  
3 what is written is true, that the highest scoring  
4 organization would have the highest reward, but if the  
5 points are very similar, the size of those rewards and  
6 penalties may be very small. So they would not be at the  
7 ends of that distribution. It may be only a few tenths of  
8 a percentage point reward and a few tenths of a percentage  
9 point penalty.

10 MS. MARJORIE GINSBURG: Okay. So it is relative  
11 to the size. The difference between the scoring determines  
12 the size of the reward or penalty.

13 DR. JOHNSON: Yes. That is part of it, and the  
14 other aspect that determines the size of any reward or  
15 penalty is the distribution of enrollment within those  
16 parent organizations.

17 MS. MARJORIE GINSBURG: Okay.

18 On page 17 of the report, Table 2, are some more  
19 important than others of the various measures here, and  
20 will they be weighted? Or do they all have equal value?

21 MS. TABOR: So we did in our modeling apply a  
22 weighting system for the six measures that we included in

1 the modeling, and we followed CMS's lead on the weighting  
2 that they apply for the quality bonus program, where the  
3 outcomes measures are weighted at 3 and the process  
4 measures are maybe about 1. So, in our modeling, the  
5 breast cancer screening have the lowest value, but the  
6 hospitalizations have the highest.

7 MS. MARJORIE GINSBURG: Okay. And I may be  
8 getting redundant here. I'm trying to get it right. Is  
9 the reward/penalty for this table then based on cumulative  
10 scores of all five categories, or is each one weighted  
11 separately?

12 MS. TABOR: So I think that would be something  
13 that policymakers could consider as to whether the weight  
14 the domains or whether to weight the individual measures.

15 In our modeling for the six measures that we  
16 used, we didn't kind of follow the domain, just because we  
17 only have six measures. So we weighted each measure  
18 individually and, again, kind of gave higher preference to  
19 the outcome measures.

20 MS. MARJORIE GINSBURG: Okay. I may have some  
21 more later, but that's it. Thank you.

22 DR. PAUL GINSBURG: Okay. As I keep looking this

1 way first, I'm going to do the people I have on the other  
2 side. Amol?

3 DR. NAVATHE: So a quick question, because we had  
4 debated in the past about this notion of the prospective  
5 element of the scoring versus tournament typical model. In  
6 some sense, is that here, the prospective piece? Is that  
7 sort of a distinction without a difference? Because we end  
8 up doing the assessments at the local market level and  
9 adjusting, as we just talked about, and although there is  
10 some predictability in terms of if my score goes up this  
11 much, I get this many points, at the end of the day, the  
12 dollar amount that I get is still dependent on what happens  
13 in my local market.

14 MS. TABOR: That's accurate, yes.

15 DR. NAVATHE: Okay.

16 MS. TABOR: There is still a relative nature to  
17 the system.

18 DR. NAVATHE: Okay. Thanks. I just wanted to  
19 make sure I understood.

20 DR. PAUL GINSBURG: Sue?

21 MS. THOMPSON: Thank you all.

22 Talk a little bit more about the 2 percent and

1 what sense we have that that's enough to motivate behavior.

2 DR. JOHNSON: I don't know that we have looked at  
3 any of the literature that suggests what percent is the  
4 right amount to motivate behavior. I think originally in  
5 the original conception of the Commission's view of what a  
6 quality incentive program would look like in the MA  
7 program, it was to be a small percent. So we started with  
8 a small number.

9 I think purely for modeling purposes, one of the  
10 things we wanted to see was what the distribution of  
11 rewards and penalties was and see whether or not they  
12 tended to fit the entire two or even smaller, since we  
13 found they're even smaller. So that certainly is a  
14 parameter that I think could be figured out when  
15 implemented.

16 MS. THOMPSON: So it was used for modeling  
17 purposes?

18 DR. JOHNSON: Yes.

19 MS. THOMPSON: Okay. So as the cliffs go away  
20 and the geographies get smaller, how do we think about --  
21 or how do you think about what happens with scale impacting  
22 the results?

1           In other words, do we need to worry about that  
2 with the cliffs going away? As the cliffs go away, how do  
3 we think about the impact scale will have, because these --  
4 as the geographies get smaller, the numbers will get  
5 smaller. How will scale affect the results?

6           DR. JOHNSON: Do you mean scale of the parent  
7 organization?

8           MS. THOMPSON: Mm-hmm.

9           DR. JOHNSON: So in our analysis, as we've done  
10 it, each parent organization with a market is treated  
11 separately for each market that they participate in. So  
12 there still might be some dynamic that larger parent  
13 organizations in a market, you know, might have different  
14 results. But the national aspect of the parent  
15 organizations that is driving a lot of the QBP results, I  
16 think a lot of those negative aspects are mitigated by  
17 looking just at the market level.

18          MS. THOMPSON: And my final question. In parts  
19 of the country where there's not a great prevalence of MA  
20 products, where they might be one plan offered, any  
21 thoughts about what might happen in those markets to the MA  
22 opportunities to the beneficiaries?

1 MS. TABOR: So we have thought about this, and I  
2 think a couple of different options could be is that those  
3 plans are still included in the value incentive program.  
4 Perhaps they join the next contiguous area. Perhaps the  
5 enrollees that are tied to that area are then also kind of  
6 tied into plans in the next contiguous area. So I think  
7 we'd want to kind of put in -- or CMS should kind of put in  
8 place opportunities to evaluate and hold as many enrollees  
9 as possible.

10 MS. THOMPSON: Thank you.

11 DR. PAUL GINSBURG: So Jaewon is next.

12 DR. CROSSON: Okay. Jaewon?

13 DR. RYU: Sure. I had two questions. One was  
14 around the peer grouping around the dual eligibility. It  
15 seems like that would introduce some state-by-state  
16 variability, given the Medicare eligibility component. Is  
17 that significant? Not? Have you all looked at that?

18 MS. TABOR: We have thought about it, yes, and  
19 that's kind of one of the reasons we chose full dual as  
20 opposed to partial dual, because the variability really  
21 comes into play more when you're looking at the partial  
22 duals.



1 DR. RYU: Okay. How much variability still  
2 exists, though, even with the full dual criteria?

3 MS. TABOR: We can come back and explain that  
4 more.

5 DR. RYU: And then the other question was -- and  
6 you cover some of this on Slide 17 -- between the MA-VIP  
7 and the current QBP, how do -- I'm wondering if there's a  
8 way to further stratify, because so many plans right now,  
9 82 percent of beneficiaries are in a star bonus  
10 environment, right, under the QBP. But within that is it  
11 possible to sub-segment into plans that are, quote/unquote,  
12 "higher performers" versus those that may not be as high  
13 but still qualify for the bonus, and how would this change  
14 impact them? You know, currently they get the bonus, but  
15 then in the new MA-VIP, how do they land? Something like  
16 that would be a good picture to have.

17 MS. TABOR: We can look at that more, yeah.

18 DR. CROSSON: Jon.

19 DR. PERLIN: Yeah. Thanks for your work on this.  
20 It makes good sense to gain insight into performance at the  
21 market level. This is my own limited understanding of this  
22 but I want to make sure I've got this right.

1           So the performance is calibrated nationally, but  
2 with two different markets. Assume two different markets  
3 with equal risk populations. Could better performer in a  
4 worse market, or worse-performing market, actually do  
5 financially better on the return than a worse performer in  
6 a better-performing market?

7           DR. JOHNSON: Yes.

8           DR. PERLIN: Okay. So that's just -- okay.  
9 That's good on that one.

10           In moving budget neutral, which, you know, has a  
11 symmetry with the other programs, do we expect any added  
12 downstream pressure on providers given obviously net-  
13 negative margins that providers experience for Medicare  
14 beneficiaries in the first place?

15           MR. ZARABOZO: Well, potentially. I mean, we  
16 don't -- that is one possibility. As we mentioned, if, for  
17 example, a plan says we don't think we can reduce the extra  
18 benefits so we have less money and, therefore, we will have  
19 to cut costs somehow. So either cut administrative costs,  
20 reduce our profits, or pay less for the Medicare coverage.

21           DR. PERLIN: Thanks.

22           DR. CROSSON: Pat.

1 MS. WANG: Great work as it continues to evolve.  
2 Am I correct that the vast majority of Medicare Advantage  
3 plans also offer the prescription drug benefit?

4 DR. JOHNSON: Yes.

5 MS. WANG: So what happens to the PDP or the Part  
6 D quality metrics, which, you know, previously I think  
7 there were 14 of them. I mean, what is your thinking about  
8 an MAPD that would participate in this streamlined program  
9 for MA, but what happens on the Part D side?

10 MS. TABOR: I will say that we have been thinking  
11 exclusively just for the MA part of the program, and at  
12 this time have not thought about the Part D. But if the  
13 Commission would like us to, we can kind of take that on  
14 also.

15 MS. WANG: I just would observe that if you leave  
16 the -- you know, 14 measures there and whatever it is, 5,  
17 on the MA side, it's something to think about. There are a  
18 lot of plan administration measures in the Part D side.  
19 It's hard, I know, because the majority of people are in  
20 freestanding PDPs, but it's far too common. I guess it  
21 would be good to think about that.

22 On the HOS, I think it was great that the paper

1 acknowledged the need, or encouraging CMS to make  
2 improvements in that. And maybe since there is an expert  
3 sitting at the table she can comment too. But other than  
4 small sample size -- because I remember in previous reports  
5 you guys were like pretty critical of the HOS and the  
6 value, because I think it was the small sample size and the  
7 differences were so small. Do you think that increasing  
8 sample size is the thing that needs to happen, or are there  
9 additional things to suggest to make the HOS more reliable,  
10 since it's going to now drive such a bigger part of the  
11 program?

12 MR. ZARABOZO: Well, in this modeling exercise  
13 we did see differences among plans, even at the small  
14 sample size level.

15 MS. WANG: Okay.

16 MR. ZARABOZO: So, I mean, our concern was  
17 previously the way it was reported of, you know, how do  
18 plans fare compared to the national average essentially, in  
19 terms of who did or didn't improve, and, you know, how far  
20 away from the national average were they. So it turns out  
21 few plans are far away from the national average. But  
22 there are distinctions, even in our modeling, on the two

1 measures, the mental health and physical health measures.

2 MS. WANG: Okay.

3 MR. ZARABOZO: And we also say, you know, we  
4 would like fee-for-service to also have an HOS --

5 MS. WANG: Would you recommend that caps and the  
6 HOS survey volume sort of be by local market area? So  
7 that's implicit in this. I got it. Okay. Okay.

8 Question about the dual versus non-dual and  
9 adjustment for SES. Did you consider -- so the current  
10 stars program has got an SES adjustment based on proportion  
11 of LIS members, which is a federal definition, and it gets  
12 to Jaewon's concern, I think. Did you have the ability, or  
13 do you have the ability to sort of compare your modeling of  
14 dual versus non-dual against that sort of adjustment they  
15 have, and whether the high-LIS plans fare the same?  
16 Because you wouldn't want to go backwards in terms of  
17 recognizing SES factors.

18 MR. ZARABOZO: Well, we can do that, and that was  
19 one of the points of the bar charts, various bar charts,  
20 that said, by the way, for example, the under-65, 40  
21 percent of whom are dual, we still have an issue with you  
22 might need further stratification of that population. So

1 if there are differences -- and there are state-level  
2 differences. For example, in California everybody is a  
3 full dual pretty much. You don't have the frequency of  
4 partial duals that you see in other states.

5           So, I mean, we did this partly for simplicity, in  
6 terms of showing, yes, when you stratify in this manner and  
7 do it at the local level you get very different results  
8 from what we're seeing today. So you could do further  
9 stratification. But again, when you're dealing with small  
10 numbers, or it could be in a state situation, you could do  
11 partial and full. But in none of the states you say, well,  
12 it doesn't make any sense in this state to do that kind of  
13 stratification.

14           MS. WANG: Or even picking up a page from what  
15 CMS does currently, which looks -- sort of makes point  
16 additions based on the increasing proportion of LIS members  
17 to total members. I mean, they have that table. There are  
18 10 deciles and then there a disability table.

19           MR. ZARABOZO: Right. But I think our proposal -  
20 - the MA-VIP is better in the sense of -- so you could have  
21 a plan in an area that has, let's say, 10 percent duals,  
22 and they don't do well at all for the duals. But because

1 they're 90 percent non-dual they are a bonus plan. They  
2 have a competing plan, and this is 100 percent dual, and is  
3 not doing well because they're all duals.

4           So this situation just compares how do you  
5 perform for duals versus how do your competitors in the  
6 area perform for duals. You are getting more money than  
7 the organization where we have isolated their dual  
8 performance compared to your dual performance.

9           MS. WANG: Right. Right.

10          MR. ZARABOZO: Different from what the PDP does.

11          MS. WANG: Okay. On the budget neutrality issue,  
12 which, you know, I think is a challenging issue, question -  
13 - the first time you presented this it was -- there was a  
14 separate presentation on benchmark reform. So is this  
15 recommendation on budget neutrality going to still be a  
16 completely separate conversation from benchmark reform?  
17 Because, you know, the benchmarks were created in tandem  
18 with the creation of the current, you know, quality  
19 program, the stars program. So how are you thinking about  
20 that?

21          DR. MATTHEWS: Right. So given the prior  
22 Commission discussion, I think back in November when we

1 presented the last iteration of the MA-VIP work in the same  
2 meeting as our benchmark discussion, there was some concern  
3 about the potential cumulative impact of discussing both of  
4 these policies at the same point in time. And given that  
5 our work on MA-VIP was further along, and given the fact  
6 that there is some urgency to being able to assess the  
7 quality of care provided under the auspices of MA, we've  
8 decided to move ahead with this policy first. We can  
9 continue to explore the benchmark work that we first raised  
10 in November, but that would probably be on a longer track,  
11 and we'd like to see if we could get some resolution here  
12 first before we proceed.

13 DR. CROSSON: Okay. And I think I'd extend that  
14 a little bit more. We have other -- without getting into  
15 the details right now, we have other MedPAC recommendations  
16 with respect to MA reimbursement that are already  
17 outstanding. So just as was done with this presentation,  
18 which is to look at the economic impact, potential economic  
19 impact on plans of this change, it's my thought that as we  
20 approach others, including the benchmark issue, at that  
21 time we look at, you know, in a transparent way, the  
22 potential cumulative impact of that change compared with



1 this change compared with the other changes that we already  
2 have on the docket, and make sure that, you know, we are  
3 going where we think we ought to be going with respect to  
4 MA reimbursement.

5 MS. WANG: Okay. Thank you.

6 Final question. I didn't see anything in here  
7 that translates these results into beneficiary information.  
8 Is the intent -- I mean, I know that there was a reference  
9 to focus groups, and people said that they didn't pay  
10 attention to the stars. I think there's different  
11 information on the ground that people do pay attention to  
12 the stars. So what's your thinking on that?

13 MS. TABOR: I think we wanted to focus the  
14 discussion on just the payment side, because I think that  
15 there is a lot to be done with also what's shown to  
16 beneficiaries. I think that there is general alignment, in  
17 particular, of this program using local market area  
18 reporting, because that will allow for better information.  
19 So I think we're kind of focusing the discussion again on  
20 the payment side, with the potential to look at the  
21 beneficiary side later.

22 MR. ZARABOZO: I would also add that the current

1 situation is, as you know, the stars reported to  
2 beneficiaries are the adjusted stars. So if you're getting  
3 a bump-up because you have a high proportion of duals, the  
4 stars that the beneficiaries see say that you are, for  
5 example, a four-star plan. Now this gets to Jonathan's  
6 point, Jon Perlin's point about, well, that may be or not.  
7 Maybe you're actually at three stars if you look at the  
8 performance based on a national scale, as we're doing. All  
9 of your measures taken together, you're at three stars, but  
10 you get a bump-up because of your proportion of duals.

11           So I think people need to be aware that if we're  
12 looking at the market level, it's possible -- what may  
13 happen is that what will be reported is this particular  
14 plan, for its duals, performs here. Here's where it is in  
15 relation to the plans in this market, and here's where it  
16 is in relation to the national standard that's established.  
17 They're number 2 in this market but they're number 52 in  
18 the nation if you're looking at this particular  
19 categorization of people.

20           So I think this could be an improvement, just in  
21 terms of the public reporting issue, I guess, compared to  
22 the PDP.

1 MS. WANG: It sounds like that is a rich area for  
2 conversation that is going to be taken up another time. So  
3 you're not intending to cover that here. Okay.

4 MS. TABOR: No. I'm creating job security for  
5 myself.

6 [Laughter.]

7 DR. CROSSON: Okay now. I've got Dana and then  
8 Larry. So Dana?

9 DR. SAFRAN: Thank you. Just three questions  
10 from me. One is, near the end of the presentation, Carlos,  
11 you were talking about the transition year in the middle,  
12 and in the first year of the new program that the bonus  
13 potential would be 1 percent before it gets to 2 percent.  
14 What was the rationale for starting there, given that we're  
15 already -- plans are already taking a hit?

16 DR. JOHNSON: I think just to make sure that  
17 plans had at least a year under their belt with feedback of  
18 how their performance is under the new VIP program, and  
19 that the impacts of those, of that performance, those  
20 results, wouldn't be quite as big, but --

21 DR. SAFRAN: On the penalty side, in other words.

22 DR. JOHNSON: Yeah, on both sides, but yes, more

1 out of concern of the penalty side.

2 DR. SAFRAN: Got it. Okay. Second question  
3 relates to something somebody asked, I think Marge, that  
4 somebody over there asked, about the 2 percent. Maybe it  
5 was you, Sue. Have you looked at that as relative to  
6 margin? Because Larry and I had been having that  
7 conversation over here, and, you know, I only know one plan  
8 that I work for. But I think, you know, 2 percent bonus  
9 would be quite motivating, because it's pretty close to the  
10 margins that plans have. But what do we know about that?

11 MS. TABOR: I think we, again, just kind of  
12 picked 2 percent as something to model, and would think  
13 there needs to be more discussion about what the proper  
14 withhold is. And part of that decision should take into  
15 account the margins. And, you know, there's also kind of  
16 other options of perhaps transitioning into further  
17 withholds over time, which a lot of programs do.

18 DR. SAFRAN: Yep. Okay. Last question, which  
19 may be the most complex one. But help us understand how,  
20 with the new approach to target setting, as well as the new  
21 approach to scoring being local, how is it that a plan  
22 knows the performance targets? Because you said they're

1 prospectively set. So how do they know the performance  
2 targets for them, for the coming measurement period?

3 MS. TABOR: So what they'll know is, if I have a  
4 readmission rate of 16, and they'll be able to see that if  
5 I improve that rate to 15, I'm going to get 2 more MA-VIP  
6 points. And they won't know exactly what are the dollar  
7 amounts tied to those points, but know kind of the  
8 magnitude of how much of a change in their performance  
9 means a change on the scale.

10 DR. SAFRAN: Got it. Thank you.

11 DR. CROSSON: Okay. Thank you. Larry.

12 DR. CASALINO: Yeah. Great work. As far as I'm  
13 concerned, the sooner this would get in I think the better.  
14 I guess this is supposed to be a question. Do you think  
15 that the sooner this --

16 [Laughter.]

17 DR. CASALINO: But, really, it's great work, and,  
18 of course, the simplicity of it is very welcome after the  
19 Part D discussion.

20 So just one comment -- question. So back to this  
21 net and withhold thing. And Jay asked if someone were to  
22 get a 1.5 percent bonus, they get their 2 percent back and

1 they get the 1.5 percent. Correct? And it goes the other  
2 way -- does it go the other way as well? If you were to  
3 get a 1.5 percent penalty, you don't get your 2 percent  
4 withhold back and you also get -- no. You just -- so I  
5 give 2 percent -- I get a 2 percent withhold, and then I'm  
6 projected to -- I'm a little bit worse than average on  
7 quality in my market so I would get what you guys call in  
8 the report a half a percent penalty, say. How does that  
9 relate to the withhold?

10 DR. JOHNSON: So the first step, and our first  
11 conceptualization of this, would be a 2 percent withhold,  
12 and then there is a give-back amount, and based on our  
13 results that give-back amount would be between half a  
14 percent and 3.5 percent. So the net is a negative 1.5 to a  
15 positive 1.5 percent adjustment.

16 I think what we may have confused you, a few of  
17 you, a little bit by is one concern might be that if the  
18 payment adjustments are relatively small, withholding a  
19 large amount of money from the plans and then giving most  
20 of that money right back to the plans, with some  
21 differences here and there, might not be a necessary use of  
22 all of that money.

1           And so an alternative would be instead of  
2 applying a withhold and giving most of that money back,  
3 just in slightly different configuration, an alternative  
4 would be to come up with a payment adjustment, and this is  
5 how the hospital value incentive program works as well, in  
6 which, in a practical sense, no money is actually withheld  
7 but a payment adjustment is calculated based on the numbers  
8 on the slide that's up right now. And then those  
9 adjustments would be applied in a future, or the next plan  
10 payment year, as an adjustment.

11           DR. CASALINO: So it may just be me, but I think  
12 I'm more confused now than I was. I think the concept is  
13 simple, but I still don't quite get it. The fact that Jay  
14 and I, and maybe other people, couldn't just -- this has to  
15 be understood at kind of a first sight, I think, because  
16 it's really important.

17           So if I do -- when you talk about a 1.5 plus or  
18 minus range, as your example, how does that relate to the 2  
19 percent?

20           DR. JOHNSON: That is assuming, in the original  
21 conceptualization, that if you get a -- a plan has withheld  
22 2 percent, if they got back only a half a percent of their

1 payments, they would effectively have a penalty of negative  
2 1.5 percent. However, if they got back an equivalent of  
3 3.5 percent of their total payments, they would then have  
4 an effective reward of 1.5 percent.

5 DR. CASALINO: Okay. I think it's just real  
6 important that this be clear, probably in multiple places  
7 in the write-up, because if anybody gets confused by it,  
8 it's not good.

9 And then my only other question is --

10 DR. NAVATHE: On that point.

11 DR. CASALINO: Yeah.

12 DR. NAVATHE: So what will help is to sort of  
13 simplify what is the "financing mechanism" for the budget  
14 neutrality, which is the 2 percent, and separate that from  
15 what is the actual bonus or penalty that's paid, which is  
16 what you have up here, which in essence can be conceptually  
17 separated from the financing mechanism. That should  
18 hopefully clear it up.

19 DR. CASALINO: Yeah.

20 MS. TABOR: That's a good point.

21 DR. CASALINO: So the national versus local  
22 competition, let's just call it, or geographic area for



1 rewards and penalties, you give some discussion of why not  
2 to do it on a national level, and one reason is that plans  
3 can move, right? So if they're done on a national level,  
4 you might have small areas where there wasn't any plan at  
5 all. But you don't really -- so there's really three  
6 alternatives. You could do it all local, all national, or  
7 some mix, and within the "some mix" there could be any --  
8 you know, it could be 80-20, 90-10.

9           Do you think it would be helpful to have some  
10 discussion of the pros and cons of some mix, you know,  
11 mostly local but some national, in terms of measuring  
12 performers and how it should be rewarded? So I'm not  
13 really taking a position on that, but just discussing the  
14 pros and cons of that.

15           I will say -- and this is probably the last thing  
16 I'll say -- on the top of page 23, you have a little  
17 discussion of local versus national, but you mix in with it  
18 the whole contract problem -- "Oh, we want to do local  
19 because of the contract problem." And I think that's  
20 relevant in the sense that you only want to measure in one  
21 little area so there can't be the shenanigans with the  
22 local, the contracts. But it isn't really relevant -- once

1 you just pick and you say, okay, I don't care how many  
2 contracts this plan has, we're only going to measure them  
3 one at a time in this local area, that can be done. But  
4 that's a separate issue from whether we would just reward  
5 based on local performance or we would reward based on  
6 national -- compared nationally or compared to local mostly  
7 and a little bit compared to nationally. It's a separate  
8 issue, and I don't think they should be mixed together like  
9 they are at the top of page 23. But, in any case, more  
10 discussion of the pros and cons of that third alternative  
11 mix I think would be useful.

12 DR. JOHNSON: That's a good point.

13 DR. CASALINO: That comes up a lot in the ACO  
14 area.

15 DR. JOHNSON: So we've talked about the  
16 difference between evaluating quality at the local level  
17 versus distributing any rewards and penalties at the local  
18 level, so we can separate those out more.

19 MS. TABOR: And I would also like to add this  
20 point of having kind of a mix, national versus market level  
21 approach, is something that we haven't considered. And I  
22 would actually ask the Commissioners to comment on that

1 because the immediate con that comes to mind is that it's  
2 complex and it still could create kind of incentives to go  
3 to some markets over others. So, again, I would just kind  
4 of ask that we talk about this idea more if others are  
5 interested in it.

6 DR. CASALINO: I don't think it would be that  
7 complex, but depending on the amount of national weighting  
8 in it, if you gave a lot of weight to the national, then it  
9 would still be a big incentive for plans to move. But even  
10 10 percent might be an incentive for plans to move. That's  
11 what I think could bear more discussion.

12 DR. CROSSON: Okay. We're going to move on to  
13 the discussion phase now. Let's put up Slide 19. I think  
14 that's the best one for this purpose. We're looking for  
15 comments in terms of general support of moving in this  
16 direction. We've already had a few ideas about how to  
17 tweak or improve the policy option, but we'd also be  
18 looking for others. And Dana is going to begin.

19 DR. SAFRAN: Thank you. You know, I'm in full  
20 support. I think this is really exciting work. As you've  
21 pointed out here, overall we're trying to move to more  
22 value-based payment, and we have here a program that's got

1 about a third of our enrollees, and our approach to  
2 rewarding payment has been costing about \$6 billion and not  
3 delivering a whole lot of value to beneficiaries. So I  
4 fully support what you've outlined here, and, in  
5 particular, I'd call out a few features of this that are  
6 really, I think, differentiated from the program, the QBP  
7 program, that you propose to move away from.

8           One is parsimony with an outcomes-oriented  
9 measure set is, I know, a philosophy you're trying to take  
10 as you go through each program area for quality across  
11 Medicare. But it really is, I think, quite well done here.  
12 I do really like that you've kept in some of the important  
13 preventive measures, as I think Commissioners urged last  
14 time we discussed this, but also really kept an outcomes-  
15 oriented focus and added in -- or, you know, depending on  
16 how we look at it from the program we'd be moving away  
17 from, retain the functional health outcome measures that  
18 are collected through a health outcome survey.

19           There's been some discussion and Pat pointed out  
20 some of the Commission's previous reports that were  
21 somewhat critical about the HOS survey measures and the  
22 fact that they didn't really appear to be differentiating

1 very much across plans. I think I'd say a couple things  
2 about that since it's an area that I've done quite a bit of  
3 work in.

4           One is, you know, before any area of performance  
5 is incentivized or incentivized strongly -- and I think  
6 this would be more strongly incentivized in this program  
7 where there are fewer measures than it is in the current  
8 program -- it shouldn't surprise us that we don't see those  
9 who are being measured differentiating themselves, right?  
10 I know in the commercial world -- I don't know if it was  
11 the same in Medicare -- we saw the same thing for  
12 readmissions before readmissions mattered, right? And yet  
13 we are for sure seeing that that doesn't mean that it's not  
14 possible to differentiate performance on readmissions. You  
15 simply have to make it something that matters.

16           So I do think that it is possible for plans to  
17 differentiate themselves on performance relative to  
18 functional status and well-being. And, quite honestly, if  
19 we're not trying to do that very core aspect of health  
20 that, you know, is really at the heart of what health care  
21 should be trying to accomplish, then, you know, really what  
22 are we doing? So I love that you have that in there.

1           I think we should contemplate the idea of how we  
2 might have the use of that survey or of other patient-  
3 reported outcome measures, start to look specifically at  
4 subpopulation groups for whom the condition that they have  
5 and the treatments available really should lead to  
6 differentiated improved functional status or well-being,  
7 right? Patients with depression, patients with  
8 musculoskeletal conditions, because I think that would even  
9 help strengthen this area of measurement.

10           A couple final things. I really love the way  
11 that you have moved to the local measurement. I was  
12 thinking about the same point that Larry raised about, you  
13 know, should we consider a blend, and, you know, something  
14 that you all said in responding to that I think was a good  
15 point, which is that we could consider having the blend for  
16 the rewards component but not for the reporting component,  
17 because part of what is great about the local measurement,  
18 in addition to the points that you've raised of, you know,  
19 not causing plans to hop around market to market but,  
20 rather, really compete for performance in the market that  
21 they're in, which is great, is the information for the  
22 beneficiary, right? It's that, you know, the performance

1 data should be very close to the experience they will have  
2 in that plan, should they choose it, and that's always what  
3 we're looking for when we're reporting performance data.

4           So I wonder if we could begin to blend in  
5 national so that the -- not for the public reporting part,  
6 but for the reward part. And the reason for that -- and I  
7 understand your points, and I agree with them -- that we  
8 have to do that carefully so we don't undo the goodness of  
9 measuring at the local from the perspective of plans  
10 choosing markets to be in, but a good reason to do that is  
11 we don't want to kind of allow there to perpetually be  
12 markets that are just where performance is low. So we  
13 somehow have to start to bring in that national benchmark.

14           I think my last point that I was going to make  
15 about what I loved about it is, of course, the way that  
16 you're setting the targets, getting rid of the cliff, so  
17 that performance is continuously motivating improvement and  
18 having the performance targets known prospectively. I know  
19 from my own work how motivating that is to those who are on  
20 the receiving end of the measurement, and we saw really  
21 dramatic and sustained improvements over 10 years of  
22 studying this when we moved to a methodology like that, so

1 I really applaud that move. And that was my summary.

2 DR. CROSSON: Dana, let me just ask you one  
3 question. How would you -- what do you feel about the  
4 notion that was described, which is with respect to  
5 reporting, that potential MA members would see the  
6 performance locally and they would see the national  
7 performance?

8 PARTICIPANT: You mean national benchmark.

9 DR. CROSSON: Yeah, right, the point being for  
10 beneficiaries, they might want to know, in addition to what  
11 they actually have available to them and how those compare,  
12 whether or not to go into MA at all based upon a relatively  
13 low performance compared with MA plans in other parts of  
14 the country.

15 DR. SAFRAN: Yeah, I guess where I'd worry about  
16 that is without showing -- you know, the way you just  
17 framed that choice is, well, if MA plans in my market don't  
18 look so hot, I guess I'll stay with traditional Medicare.  
19 But without having the corresponding data, you don't know  
20 that that's necessarily the right conclusion to come to.

21 DR. CROSSON: Okay. I agree. That's --

22 DR. SAFRAN: Yeah.



1 DR. CASALINO: But you still think it could be a  
2 good idea to show them both, but just to frame it exactly  
3 the way Jay framed it.

4 [Laughter.]

5 DR. SAFRAN: I suppose I'd want to think about it  
6 a little more. Why do we want to show them both? I might  
7 want to show them the plans in their market and then show  
8 them, by the way, you live in a market that's very low  
9 performing relative to the rest of the country, just to get  
10 some activation about like don't we deserve better here. I  
11 wonder if that would be a good way to split the difference.

12 DR. CROSSON: Jon.

13 DR. PERLIN: Yeah, this is why I asked the  
14 question, could a better performer in a lower-performing  
15 market do better than a worse performer in a better-  
16 performing market? Because I think the distinction is just  
17 to Dana's point. It's absolutely what I agree with. So I  
18 think it is useful the beneficiary potentially see the  
19 juxtaposition of the two, and you don't know, obviously,  
20 the other piece of that.

21 I think the other sort of insidious piece is that  
22 we want to relieve plans and providers of -- or recognize

1 the challenge of caring for a more socio-demographically  
2 challenging population. On the other hand, you don't want  
3 to desensitize and say, okay, from the patient perspective  
4 it's okay to get services that aren't. I mean, I think the  
5 incentive has to be how do you figure out the way to give  
6 patients who have the greatest burden the best possible  
7 outcome. And that's really tough because that operates  
8 with pressures in both directions.

9           So, you know, at one level, I think providing the  
10 information of what is relative performance is a way to  
11 solve that. Second, separating that from payment I think  
12 has utility. And the third is I wouldn't underestimate the  
13 power of public accountability or public signal of the  
14 Health Services Research, particularly where the incentives  
15 -- and Dana brings the information to what the margins  
16 area, clearly an area she knows better than I do. But when  
17 incentives are modest, I think the Health Services  
18 Research, particularly as you look at other countries,  
19 would indicate that the public disclosure and  
20 accountability is a pretty powerful signal in terms of  
21 motivation for improvement. Thanks.

22           DR. CROSSON: Okay. On this point, and then

1 we'll start -- David, on this point?

2 DR. GRABOWSKI: Not on this point.

3 DR. CROSSON: Okay. So on this point?

4 DR. NAVATHE: So I wanted to echo something that  
5 Jon just mentioned, which is, you know, we look at duals as  
6 a way to try to normalize a little bit; we do some peer  
7 grouping. But at the end of the day, it actually may be  
8 very challenging to truly adjust for all these unobservable  
9 in-claim factors. And so I think if nothing else, in our  
10 rationale around the recommendation, I think we could  
11 describe more explicitly that there is a trade-off, there  
12 is a situation that Jon described, which is a lower-  
13 performing plan in a market is actually high-performing  
14 overall, the national could be penalized, whereas you get  
15 this situation; but because we can't fully adjust for these  
16 socio-demographic or social factors that may influence,  
17 we're sort of accepting that possibility because the local  
18 market adjustment reflects beneficiary choice and doing so  
19 may actually more fully account for these unobserved  
20 factors. So I think it's worth articulating that  
21 rationale. I think that is a reasonable rationale for  
22 this, number one.

1           Secondly, I think Larry brought up the idea of,  
2 sure, we can definitely do the reporting, but we could even  
3 -- this would take us away from simplicity a little bit,  
4 but incorporate some sort of national benchmark performance  
5 also into the incentive computation, which, as I think  
6 about this, at the individual clinician level or individual  
7 practice level, I think we want to really espouse  
8 simplicity as an important value. When it comes to MA  
9 plans, which are sophisticated beasts, I think perhaps a  
10 little bit of complication is not the worst thing in the  
11 world. So I think it may be something to reconsider  
12 potentially.

13           DR. CROSSON: Okay. So now let's have the  
14 general discussion. I saw David, I see Marge. All right.  
15 Let me see. David, Marge, Bruce, Amol, Pat, Jonathan,  
16 Brian. Got everybody?

17           DR. GRABOWSKI: Great. I'm first. So let me  
18 start by saying I'm really supportive of this work, so  
19 thanks. This is great stuff. I just want to make one  
20 point, and that's really to pick up on the comment Jaewon  
21 and Pat were pushing you on in the first round, with does  
22 full dual status really capture or account for social risk

1 factors. And I've always had a funny feeling about this  
2 measure, and there was a paper this past month in Health  
3 Services Research that really confirmed my kind of  
4 queasiness. They used the Medicare current beneficiary  
5 survey and looked across state, how big is the variation  
6 among duals in socioeconomic risk and health risk, and it  
7 turns out, Jaewon, to your question, it's actually pretty  
8 big, about 25 percent state to state.

9           I know this is illustrative right now, but going  
10 forward -- and you have a nice footnote in the text here  
11 about, you know, over the coming cycle staff plan to  
12 research potential of peer groupings using additional  
13 social risk factors. I'm really excited about that work,  
14 and I hope you'll continue down that path, because I don't  
15 know that we're all the way there with dual status, and I  
16 think we can do better there.

17           Thanks. And further job security for Ledia here,  
18 so this is good.

19           DR. CROSSON: Marge.

20           MS. MARJORIE GINSBURG: Actually, my comment  
21 should have been attached to the last piece before we got  
22 into this, but that's okay. It's about reporting locally

1 and reporting nationally, and I'm now sort of wearing my  
2 Medicare counselor hat. Most people, if they're coming  
3 into Medicare, at least my experience only, which is this  
4 big [indicating], and they're debating between an MA plan  
5 or original Medicare, they want to know the pros and cons  
6 of both. Why would this be better for me versus this?

7           I guess I'm making an argument for not making  
8 this any more confusing than it already is, so I have  
9 reservations about reporting out nationally. I think  
10 people care what is this for me here now in my community,  
11 and I guess I'm a little concerned that they see better  
12 scores nationally, they're going to think, why are my folks  
13 so bad? And maybe I don't want this plan after all.

14           So I worry -- I think this would make a great  
15 focus group topic, if anybody wanted to take that on,  
16 Ledia. But, anyway, having said that --

17           DR. NAVATHE: But, Marge, wouldn't that  
18 potentially be a consideration we do want them to have? If  
19 they're picking to enroll in MA and if the plans that they  
20 have available to them are --

21           MS. MARJORIE GINSBURG: Well, maybe that's why it  
22 would be a good discussion group, because I don't know if

1 they would say yes, I would love to know how this  
2 particular group is nationally. But people look at their  
3 experience, and they think in terms of what they know here  
4 and now, what they can get their mind around, what are  
5 their options here, and what's happening in New York I  
6 think has very little meaning to them, or even nationally  
7 for this particular health plan. It's their doctors and  
8 the hospitals and the care they get here is important to  
9 them. But I think a focus group on this whole topic would  
10 be really worthwhile.

11 MS. TABOR: I will say that in a previous life I  
12 have done focus groups on this topic, and there's also some  
13 literature on this, and it generally does say that people  
14 do get more confused when you throw in the national  
15 numbers, and they really want to know how to make the best  
16 choice for them. But, again, there's trade-offs to that,  
17 especially when you think about the public accountability  
18 piece.

19 MS. MARJORIE GINSBURG: And just one other thing  
20 about this and the distinction between scores for the dual  
21 eligibles versus not. Maybe I'm still not exactly sure  
22 about whether one shows a combined score. So let's say

1 you've got an MA plan that has a really high level of  
2 duals, so their scores may be lower. But we're  
3 differentiating between the two when we issue them  
4 penalties or rewards. Well, does a member coming in  
5 looking at making a decision know that the reason their  
6 score is lower is because they have a very much higher  
7 level of those who are dual eligible? Well, that may not  
8 be particularly appealing to those who are not dual  
9 eligibles and don't want to be saddled with a plan who's  
10 only focused on taking care of low-income folks.

11           So, anyway, I just wanted to raise that. Aside  
12 from that, this is great work, and I --

13           DR. CASALINO: On this point --

14           MS. MARJORIE GINSBURG: -- am very excited about  
15 moving forward.

16           DR. CASALINO: So I think -- I appreciate Marge's  
17 comment. I think it's important. I think we've had a  
18 distinction already made -- I just want to bring it up  
19 again -- that one purpose of public reporting would be to  
20 help individuals in their choice, and that's probably the  
21 most important part. But there is a potential second  
22 reason to publicly report which would be in favor of giving



1 national results as well, which is possibly to generate  
2 some local impetus for change, because otherwise how is the  
3 local community -- looked at as a community, not  
4 individuals making their choice -- to know that they  
5 actually are getting inferior care as a group? So it's a  
6 trade-off between the complication at the individual level  
7 counseling. And I just realized actually it's even a  
8 little more complicated, the counseling, because we  
9 wouldn't, I don't think, report necessarily scores for the  
10 whole plan; it would be the dual-eligible part and the non-  
11 dual-eligible part. So that was one point.

12           And the other point I wanted to make I think is  
13 obvious, which is that the reporting and the bonuses can be  
14 separated. So whether or not we report national locally,  
15 it would be possible to still do some kind of national-  
16 local mix for payment. Patients don't care about that,  
17 right? The beneficiaries. But the plans do. So they  
18 don't have to be totally synchronized.

19           DR. CROSSON: Bruce?

20           MR. PYENSON: Yeah. I don't want to miss an  
21 opportunity to put in a requirement for encounter data  
22 provision here. So I'd encourage staff to think about a

1 way to do that with a contribution to the pool but no  
2 upside if encounter data doesn't flow.

3           That, by the way, isn't only pressure on the  
4 plans. I think it's pressure on the CMS to fix some of the  
5 current issues.

6           I don't see any need for a transition. The bids  
7 are done annually. There's big changes that happen year to  
8 year, and I think that can be -- I just don't see the need  
9 for that. It could be wrong, but I think we could just do  
10 this. Otherwise, I support the recommendations.

11           DR. CROSSON: Thank you, Bruce.

12           Amol?

13           DR. NAVATHE: So thank you for leading this work.  
14 I'm very, very supportive, in general, of it.

15           I agree with Bruce. I think faster ramp-up  
16 should be totally feasible here. I think they could have a  
17 reporting year where they could see how they do an MA-VIP  
18 while they're still in the current program and then  
19 transition. I think that would seem reasonable.

20           Two other points. One thing was it would be  
21 nice. I think we articulated. We did sort of sample work  
22 around the breast cancer process measure, and I think then

1 cited some limitations around data, which obviously  
2 matters. I think it would be good if we could lay out some  
3 principles or framework around how those process measures  
4 would get picked. I think we would want to look for  
5 process measures where there is variability, for example,  
6 and they're not maxed out, so there's opportunity. I think  
7 a couple of different principles would be nice to  
8 articulate since we can't do all the analysis effectively.

9           The other question I had was, if I remember  
10 correctly, when we looked at the analysis in November, it  
11 looked like the ER measure and the acute hospital measure  
12 seemed to not be very highly correlated, and so I think at  
13 the time, I had proposed the idea of maybe combining them  
14 into an acute hospital use measure. And you could just  
15 double-weight it, for example, if we wanted. I was  
16 wondering if we had given any further consideration to that  
17 or if there was an explicit decision to not do that.

18           DR. CROSSON: Pat?

19           MS. TABOR: I'm working on it. So I think there  
20 were also other suggestions on how to improve the measure  
21 that I plan to work on in the summer.

22           DR. NAVATHE: Great. Thanks.

1 DR. CROSSON: Pat?

2 MS. WANG: So I think that a lot of this is  
3 fantastic, you know, smaller set of measures.

4 I do like the local market level. I think the  
5 discussion has been interesting, and I'm really very moved  
6 by Marge's comments.

7 To some of the other comments about wouldn't you  
8 want to know that your plan is not good compared to the  
9 national, but maybe the fee-for-service system is even  
10 worse compared to the national. So you are only getting a  
11 piece of the picture. So I worry a little bit about the  
12 kind of incomplete messages there.

13 I think the local market-level measurement is  
14 more appropriate for a lot of reasons, just because health  
15 care is local, and beneficiary information, it's like  
16 what's in front of you, what are your choices, and so I  
17 would just stick with that.

18 Endorse the sort of suggestion to maybe look a  
19 little bit more deeply at some of the peer grouping and how  
20 to adjust for SES, and all I was trying to suggest before  
21 was if there were a way in the modeling to compare these  
22 results with just dual/non-dual as opposed to carrying over

1 some of the current star stratification based on LIS  
2 percentage and disabled percentage to see if there's a  
3 correlation, even, about how plans perform, it might be  
4 valuable.

5           Elimination of the cliff is fantastic. I do  
6 think it would be important to figure out which two with  
7 the Part D quality measures, because otherwise you're going  
8 to have a really lopsided program with plans, MA-PDs,  
9 continuing to work on 14 Part D measures. It's just very  
10 lopsided. So there has to be some way to bring those  
11 together.

12           I have the greatest difficulty with the budget  
13 neutrality aspect of this because I think implicit -- and  
14 perhaps it should just be directly stated -- is that this  
15 is a proposal to cut \$6 billion out of the Medicare  
16 Advantage program, and maybe \$6 billion is the wrong number  
17 because of the contract consolidations.

18           But one of the things that I found, just reading  
19 through the chapter a little bit, confusing and potentially  
20 -- you know, the contract consolidation, which is correctly  
21 pointed to, was the source of a lot of the reason to need  
22 to change the program. It's kind of over because of the

1 work that you guys have already done. Like the game is  
2 kind of over, and so I wonder whether some of the ill  
3 effects, the 85 percent who are on bonus status, the \$6  
4 billion is working through the hangover, because there's  
5 such a lag between performance year and payment year in  
6 stars three years. So even in 2020, we're still dealing  
7 with like currently the effects of contract consolidation.

8           I think it's a very big deal to say there should  
9 be no -- that the total structure of the program should be  
10 changed because of bad behavior or whatever people --  
11 however people want to characterize it because I think that  
12 when the program was created, it was in tandem with  
13 Congress sort of saying these are the benchmarks, a quarter  
14 of which are below the fee-for-service equivalent, and so  
15 actual payment is well below the fee-for-service  
16 equivalent.

17           So there was the benchmark structure plus you can  
18 earn extra money through stars. So I would say that at a  
19 minimum, this has to acknowledge that this is a fundamental  
20 change in the structure of the program from the way that it  
21 was originally designed, which contemplated an add-on.

22           So I wonder, for example, what was the level of

1 extra payments through the stars program before the  
2 contract consolidation thing started happening. I find  
3 that a difficult thing.

4 I understand that this report can't also address  
5 the benchmark issue, but at a minimum, I think there needs  
6 to be something stated that this is done as a proposal to  
7 restructure the financing or the shape of the MA quality  
8 program, understanding that in a budget-neutral scenario,  
9 it begs the question of what happens with the benchmarks,  
10 what happens with the original -- with \$6 billion  
11 disappearing from the system, because at a minimum, I think  
12 it needs to be mentioned.

13 And that's all.

14 DR. CROSSON: Larry, do you want to comment on  
15 that?

16 DR. CASALINO: I'll wait.

17 DR. CROSSON: Wait your turn? Okay.

18 Jonathan?

19 DR. JAFFERY: Thanks.

20 First of all, overall very supportive. I like  
21 the direction and trying to bring the principles that we've  
22 had in other areas and also would echo this idea of don't

1 see the need for the longer transition period.

2 I'll focus my comments on the national versus  
3 local point, and also, in that regard, I think it is  
4 crucial that we be able to, again, compare things with fee-  
5 for-service. And so I think taking Bruce's suggestion of  
6 trying to take this opportunity to again emphasize the need  
7 to get encounter data is important.

8 I guess I am supportive of the national  
9 reporting, and I understand the issues that folks have  
10 brought up and would want to think through that a little  
11 bit more.

12 To the extent that I think these -- the points  
13 about people understanding that maybe they do live in an  
14 area where the health care delivery is not as high quality  
15 as others and using that as motivation for people to  
16 actually try and make some local change, I think that's an  
17 important thing to consider.

18 And I would say that there's another group of  
19 individuals that tend to care pretty deeply about how their  
20 area performs relative to others, and that's Members of  
21 Congress. So this could be a powerful tool if people start  
22 to see we're putting a lot of money into MA plans. We've



1 supported this, and now why is my district or my state so  
2 low-performing compared to others?

3           The final thing I would say, putting aside kind  
4 of that issue and thinking about the complexity or not,  
5 concern over complexity or not concern over that, I think  
6 about the work that's been done in benchmarking in ACOs. I  
7 think somebody brought that up before. We could look at  
8 that a little bit more.

9           ACOs have been dealing with that, and there's  
10 some good and bad to that. There have been difficulties  
11 with dealing with that, but maybe there's some lessons that  
12 are learned.

13           And I will say that having been part of an ACO  
14 for a while now, thinking about Jon's comments about what  
15 is it like when you're in a high-performing area and you  
16 feel like you're penalized when you're doing better than  
17 people who are getting rewarded who do worse than you but  
18 are in a low-performing area, that's a real consideration.  
19 And it leads to people not trusting the program as much.

20           DR. CROSSON: Okay. Thank you.

21           So what I've got left is Brian, Paul, and Larry.  
22 Then I think we're going to finish.

1           Okay.  Brian?

2           DR. DeBUSK:  First of all, thanks again for some  
3 really great work.  I mean, obviously, this is a big step  
4 in the right direction because it's very consistent with  
5 what you've been doing with HVIB and some of the other  
6 things.

7           I love the no-tournament models, no cliffs.  I  
8 mean, all that's been said before.

9           I do want to mention -- and a number of people  
10 have talked about this -- there may be a method for  
11 payment, say a blended local-national method.  There may be  
12 a method for comparing MA plans, say replacing the stars,  
13 but I think -- and you saw this with Dana and Larry who  
14 started this, and it keeps coming back up again.  
15 Ultimately, you're going to have to be able to compare MA  
16 and fee-for-service.

17          And I think of it as like a Venn diagram.  I  
18 mean, there may be things that just don't exist in fee-for-  
19 service that MA has and vice versa, but as you guys are  
20 designing these programs, I think we could be too  
21 idealistic and say, "Oh, they all have to be intrinsically  
22 comparable."  I think you guys have shown that just doesn't

1 work.

2           For example, I think your treatment of the low  
3 SES people, the duals, the way you've peer-grouped them  
4 differently, I think it's very novel. I mean, I think it  
5 was necessary and good, and I think it's sound.

6           But I do hope that as you guys are designing  
7 these programs -- and I suspect you are -- at least by the  
8 water cooler, you're thinking of what common  
9 characteristics do these programs have. How could we pull  
10 all this back, even if it's just a tiny set of core  
11 matures? Maybe it's just mortality and readmissions and ED  
12 use rates. I mean, it could be something that simple.

13           But you're back to -- and I think Marge raised  
14 this issue. I mean, when someone says, "Do I choose MA?  
15 Do I choose fee-for-service?" I think our answer is going  
16 to have to be "It depends," because it depends on where you  
17 are.

18           And I do hope -- and, again, I know this is so  
19 easy to proselytize at a public meeting, which you guys  
20 have to go back and actually figure this out. If you could  
21 figure out what that small overlapping set of measures are  
22 and just work with that in mind.

1           The second thing I want to mention is back to the  
2 idea of making it budget-neutral. I think that there is an  
3 opportunity here to generate some program savings and to  
4 pay MA plans less. I would love to see, though, when we do  
5 the recommendations -- and HVIP, the technical treatment of  
6 the quality program, and then a discussion or  
7 recommendation around the budget neutrality or the cut, if  
8 we could tease those two apart and just have a thoughtful  
9 discussion. Since I've been on the Commission, we've  
10 talked about doing a further adjustment for coding  
11 intensity in the 2 to 3 percent range. I think we may even  
12 have an outstanding recommendation. So that's about \$6  
13 billion. I'm just, you know, swagging here.

14           I saw the presentation on removing the cliffs  
15 from the benchmarks, which is about another \$6 billion.  
16 This is about another \$6 billion, again, round numbers, but  
17 you could be looking at \$18 billion worth of standing  
18 recommendations. And it would be nice. Maybe the number  
19 is \$18 billion; maybe the number is 6. I truly don't know  
20 what the adjustment needs to be, but it would be nice to  
21 see almost an independent discussion, because consider  
22 this. Let's say the number is 6. Would you rather take

1 the number out of the benchmark and leave the 6 in quality,  
2 or would you rather take it out of quality and leave it in  
3 the benchmark? I mean, which one is a step toward value-  
4 based care?

5 I'm just thinking even if we decide that \$6  
6 billion is the right number, this might not be the  
7 compartment that we want to take it out of. Again, I don't  
8 know. I'm going to count on you guys and presentations to  
9 answer that.

10 DR. JOHNSON: I just want to say I don't think  
11 the outstanding recommendations stack up quite that way to  
12 suggest that it would be an \$18 billion cut, but I think  
13 the biggest aspect of the \$6 billion we're talking about  
14 related to the quality program is that it's before any  
15 changes in bidding behavior. So if bids did not change at  
16 all and the benchmarks came down 5 or 10 percent where they  
17 currently get that 5 or 10 percent bonus, that would be a \$6  
18 billion. But it does not mean that \$6 billion would be cut  
19 from the program automatically.

20 DR. DeBUSK: I knew that and was hoping I  
21 wouldn't get called out on it, but thank you.

22 DR. CROSSON: Okay. Paul?

1 DR. PAUL GINSBURG: Thanks.

2 I'm really glad that Andy made that comment  
3 because this is a very complex process with bids, and it  
4 just may be that if the quality bonuses go away in the  
5 aggregate, the plans bid higher. And it just means extra  
6 benefits are lower. It's not that we're going to drive the  
7 plans out of business.

8 Just a couple of comments. I'm very supportive  
9 of the whole approach. You've done a great job.

10 I think on the issue of peer groups, based on  
11 socioeconomic factors, I think the right thing to say might  
12 be that we really support that principle. We've modeled  
13 doing it with full duals, and we think that works. There  
14 probably are better ways of doing it and look forward to  
15 the evolution over time in getting better precision in  
16 making the socioeconomic peer grouping.

17 I really like the idea of blending for payments,  
18 the national benchmark with the local benchmark, because if  
19 we have an area where all of the MA plans are weak, I don't  
20 think we want to be as generous as areas where they're all  
21 very strong. And I think this kind of a blend of a  
22 national benchmark achieves that.

1 I'm still up in the air about whether I want to  
2 broadcast that or not. We can talk about that in the  
3 future.

4 DR. CROSSON: Thank you, Paul.  
5 Larry?

6 DR. CASALINO: Two things. One is I just want to  
7 reinforce Jonathan's point about the kind of morale effects  
8 of being in a high-performing area and performing higher  
9 than a plan in a lower-performing area, but one plan gets a  
10 bonus and another doesn't. This does not have good effects  
11 on clinicians or, for that matter, administrators.

12 To the extent this is happening in other  
13 programs, I think it generates a real kind of cynicism. I  
14 think it really can literally reduce physician  
15 professionalism.

16 Since probably 95 percent or more of what  
17 physicians say do that's important to patients doesn't get  
18 measured. We depend on their professionalism for them to  
19 do a good job, and that we don't really want to reduce  
20 that. So I think Jonathan's point is an argument for some  
21 national blend.

22 On the \$6 billion or whatever it is and the

1 budget neutrality, personally, I just don't see a reason to  
2 subsidize MA plans through a penalties and rewards program.  
3 I don't see it at all.

4           Just as a thought experiment, how would people  
5 feel if we said, "Okay. Let's take \$6 billion from  
6 taxpayers and put it into the accountable care organization  
7 program, and we'll just give \$6 billion more to distribute  
8 to ACOs"? I don't think that would go over very well. So  
9 I honestly don't see why we should consider doing any of  
10 that for MA plans.

11           DR. JAFFERY: We could put that and vote.

12           [Laughter.]

13           DR. CROSSON: We have had that proposal at the  
14 table, but that's for another time. All right. But now  
15 that you've quantitated it, that will move it along.

16           Kathy?

17           MS. BUTO: Just one other fairly simplistic  
18 option would be to go ahead and add some of the \$6 billion  
19 back into the base payment under budget neutrality. In  
20 other words, if Pat is right and part of the concept  
21 originally was that that was part of the payment to be  
22 distributed in a nonbudget-neutral way, you could fold that



1 in budget neutrally -- it could be less than \$6 billion --  
2 and sort of be done with it, without going cold turkey.

3 DR. CROSSON: Okay. Last comment, Jon?

4 DR. PERLIN: It gets to the question I raised  
5 about what we thought the downstream effects would be as  
6 well, and I recall, Carlos, your answer was that if dollars  
7 come out of these programs, that it can be taken out of  
8 margins, administrative overhead, the distribution of  
9 benefits the plan offers or payments to providers, and so  
10 it offers both to plans and providers a smoothing function  
11 in terms of implementation. I think that makes some degree  
12 of sense.

13 DR. CROSSON: Okay. Good discussion. A very  
14 intense morning.

15 Thank you for the presentation, Andy, Carlos,  
16 Ledia. You've been here a long time, and this is very good  
17 work. So we'll hear from you again in March.

18 We now have the opportunity for public comment.  
19 If there are any members of the audience who would like to  
20 comment, please come to the microphone. I'll give you an  
21 instruction in one minute.

22 Okay. So we would ask you to identify yourself

1 and any organization that you represent. Please comment on  
2 issues that have been before the Commission this morning,  
3 and we'd ask you to limit your comments to two minutes.  
4 And when this light come back on, the two minutes will have  
5 expired.

6 MS. UPCHURCH: Great. Thank you.

7 My name is Gina Upchurch. I'm with an  
8 organization in Durham, North Carolina, called Senior  
9 PharmAssist, which I started 25 years ago to help low-  
10 income older adults pay for medicines, manage their  
11 medicine. We're secondary to Part D. We help them get  
12 resources, stay in their home, and we're the SHIP  
13 coordinating site for Durham County.

14 I'm also on the American Geriatric Society Public  
15 Policy Committee, but I'm not here representing them.

16 First of all, thank you for simplifying the Part  
17 D drug benefit, and particularly, what we find that people  
18 have confusion is the initial coverage phase being a copay,  
19 and then when you get into the donut hole, it's a  
20 coinsurance. It's ridiculous. So having it a coinsurance  
21 all the way through makes it much more transparent for  
22 people to understand.

1           You talked about Medicare Advantage plans being  
2 something that people with more money tend to go to. We  
3 see in our area in Durham where Medicare Advantage plans  
4 are growing. Especially the D-SNPS are growing, with all  
5 the added benefits that are coming, especially oral health,  
6 dental health.

7           But please stop people from calling them  
8 "supplemental benefits" because that's super confusing  
9 trying to explain how supplements are different from  
10 Medicare Advantage plans. They should be called "perks" or  
11 "extra benefits" or something.

12           Just to point out a couple things that I hope are  
13 helpful to you, there are a lot of people that have  
14 catastrophic needs that turn to copay foundations that are  
15 often set up by pharma, companies to help people that can't  
16 afford the catastrophic. So maybe pharma will be sending a  
17 lot of money, not having to support that with this new  
18 benefit, and could use the money in other ways. That's one  
19 thing to look at.

20           The other thing I would just -- there is cost-  
21 sharing difference with people with LIS, partial LIS, up to  
22 150 percent. They pay 15 percent of the cost. People

1 between 100 and 135 percent right now are paying anywhere  
2 \$360 to \$895. They have distinction in those copays, and  
3 people below 100 percent of the federal poverty with full  
4 LIS pay \$130 or \$390. So there are distinctions already in  
5 the LIS benefit with cost sharing, just to point that out.

6           The main reason we see people that don't qualify  
7 for LIS is because the assets test is so very strict, so  
8 something to look at.

9           The late enrollment penalty is keeping a lot of  
10 people out of the benefit that should join, especially  
11 people in community health centers that have been sitting  
12 here since June 2006, because they're getting a discount,  
13 FQHCs, at the pharmacies. So now that's a barrier to entry  
14 for them.

15           DR. CROSSON: Please conclude your comments,  
16 please.

17           MS. UPCHURCH: Okay.

18           So my last comment would be please -- and this  
19 may be out of your purview, but the plan finder is -- the  
20 updates to the plan find have created incredible challenges  
21 trying to help people sort through all of this.

22           Thanks.

1 DR. CROSSON: Thank you.

2 So we will reconvene for the afternoon session at  
3 1:45.

4 [Whereupon, at 12:55 p.m., the meeting was  
5 recessed, to reconvene at 1:45 p.m. this same day.]

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1 AFTERNOON SESSION

2 [1:50 p.m.]

3 DR. CROSSON: Okay. We welcome our guests to the  
4 afternoon session of the January MedPAC meeting on  
5 Thursday, and this is a portion of the meeting, a portion  
6 of the work of the year, actually, where we spend some time  
7 making recommendations to Congress on updates to the  
8 various parts of the industry that the Medicare program  
9 pays for. And we're going to start off with the hospital  
10 industry, inpatient and outpatient, and Stephanie and Jeff  
11 are here. And Jeff, it looks like you're going to start  
12 off.

13 DR. STENSLAND: Yep. All right. So good  
14 afternoon. This session continues the discussion on the  
15 update recommendation for hospitals, and we presented a  
16 full discussion of payment adequacy indicators in December,  
17 and so today we're just going to give you an abbreviated  
18 recap of that data.

19 You will also note that on the first page of your  
20 mailing we discussed additions to the chapter where we  
21 addressed the technical issues you raised at the last  
22 meeting, and I will not go through all technical details

1 here. And finally, before I start, I want to thank  
2 Alison, Dan, Ledia, and Carolyn, who all contributed to the  
3 hospital paper that you have.

4 To recap our data from December, most payment  
5 adequacy indicators are positive. Access to care to care  
6 is strong. While there has been an increase in closures,  
7 often due to low occupancy, most hospitals have the  
8 capacity and the incentive to serve Medicare patients.

9 Quality of care is stable with slight  
10 improvements in risk-adjusted mortality and readmissions.  
11 Access to capital is strong due to strong all-payer  
12 margins. The all-payer margin was 6.8 percent in 2018,  
13 close to an all-time high. However, Medicare margins were  
14 a negative 9.3 percent in 2018. Due to a relatively  
15 favorable update in 2020, we expect them to improve under  
16 current law to about -8 percent. The relatively efficient  
17 hospitals had a slightly Medicare margin of -2 percent in  
18 2018.

19 Now let's review the current law updates for  
20 outpatient and inpatient operating payments.

21 As you can see in the shaded row, the update was  
22 1.35 percent in 2019. However, due to the expiration of

1 some statutory adjustments, it increased to 2.6 percent in  
2 2020, and is expected to be 2.8 percent in 2021. Given  
3 current CMS market basket projections, this would be the  
4 highest update in a decade.

5           As you recall, last month the chairman proposed a  
6 draft update recommendation that would differ from current  
7 law, and we'll go into that next.

8           There were several motivations behind the draft  
9 recommendation. The recommendation attempts to, first,  
10 increase payments by enough to maintain access to care, but  
11 also not increase them so much so that we can maintain  
12 pressure on providers to constrain costs to improve the  
13 long-term program sustainability. There is also a desire  
14 to minimize the difference in payment rates across sites of  
15 care consistent with our site-neutral work. Recall that  
16 the current law update for physicians have a zero percent  
17 update for them, so any increase to hospital outpatient  
18 rates will increase the differential in payment rates  
19 between physician offices and outpatient departments.  
20 Next, there is a desire to reward high-performing  
21 hospitals, and finally a desire to move Medicare payment  
22 rates toward the cost of efficiently providing high-quality



1 care. And clearly there is some tension between these  
2 objectives.

3           Next, we present the draft recommendation. This  
4 is essentially the same recommendation you saw in December,  
5 with some clarification to make it match the wording from  
6 last year's recommendation.

7           The draft recommendation reads: The Congress  
8 should, for 2021, update the 2020 Medicare base payment  
9 rates for acute care hospitals by 2 percent, and provide  
10 hospitals with an amount equal to the difference between  
11 the update recommendation and the amount specified in  
12 current law through the Commission's recommended hospital  
13 value incentive program, the HVIP.

14           This slide is the grand summary slide that  
15 summarizes the difference between current law and the draft  
16 recommendation. It can serve as a guide for your  
17 discussion. There are three broad implications of the  
18 draft recommendation relative to current law, and those are  
19 in the last column.

20           First, it would reduce the difference between  
21 physician office payments and hospital payments. Second,  
22 it would increase payments associated with delivering

1 greater value to the program due an increase in quality  
2 incentive payments. And on net, it is expected to increase  
3 payments by 3.3 percent given current inflationary updated  
4 projections, and this is due to the additional quality  
5 incentive program payments that we would have under the  
6 draft recommendation.

7           The recommendation is equivalent to the  
8 recommendation from last year and has the same score from  
9 the CBO. Relative to current law, the CBO estimates the  
10 recommendation would increase spending by between \$750  
11 million and \$2 billion in 2020, and by between \$5 and \$10  
12 billion over five years.

13           We do not expect these changes to affect  
14 beneficiaries' access to care or providers' willingness to  
15 treat Medicare beneficiaries. However, beneficiaries may  
16 benefit from hospitals' enhanced incentives to improve  
17 quality of care.

18           I now turn it back to Jay for your discussion.

19           DR. CROSSON: Thanks very much, Jeff. We will  
20 now take clarifying questions.

21           Seeing none, we will move ahead the  
22 recommendation as on page 5. The discussion will be on the

1 draft recommendation support or not, and we'll have a  
2 discussion.

3 Warner.

4 MR. THOMAS: You had to think I was going to make  
5 a comment, right?

6 [Laughter.]

7 DR. CROSSON: I was looking at you.

8 MR. THOMAS: You're looking at me. I was like--

9 So I guess a couple of comments. One, you know,  
10 I appreciate the proposal and certainly it's heading in the  
11 right direction. I guess, I mean, this isn't necessarily a  
12 clarifying question, but--

13 DR. CROSSON: No, we're past that. This is  
14 discussion.

15 MR. THOMAS: I know. I know, but it is a  
16 question.

17 DR. CROSSON: Oh.

18 MR. THOMAS: It's not a clarifying question.

19 [Laughter.]

20 MR. THOMAS: I just wanted to clarify that.

21 DR. CROSSON: Thank you for the clarification.

22 MR. THOMAS: Yeah, exactly. So I guess the

1 question I have, just generally, to the Commission and to  
2 the staff, is, you know, at what level do we think it's  
3 okay to have inpatient Medicare margins? I mean, is it -8?  
4 Is it -9? Is it -10? Is it -5? I mean, I guess, you  
5 know, we now have efficient hospitals negative, so should  
6 the target be that they be positive? I mean, I guess  
7 that's part of the question I've got. I'm trying to figure  
8 out like where are we trying to evolved this.

9           Understanding that, you know, there's not more  
10 than likely going to be an access issue for Medicare  
11 recipients, because I think it's virtually impossible for  
12 an acute care hospital to not be a participating provider  
13 in Medicare and be financially stable. Specialty hospitals  
14 can do that, because they, you know, essentially target  
15 commercial patients. But generally an acute care hospital,  
16 you know, is going to be a participating provider in  
17 Medicare because they have to be, so -- just to be  
18 financially stable.

19           So any thoughts about that, just in general?

20           DR. MATTHEWS: Yeah. I can take a stab at that  
21 one.

22           MR. THOMAS: Sure.

1 DR. MATTHEWS: You know, from my perspective,  
2 when we conduct payment adequacy analyses, we do not have a  
3 target margin in mind. We look at indicators of access,  
4 access to capital, quality of care, and, you know, we  
5 present that information along with what might be an  
6 appropriate draft recommendation for the Commission to  
7 consider. And it is up to the Commission's judgment to  
8 make a determination whether or not the recommendation is  
9 appropriate, whether it needs to change.

10 But with respect to the specific point you asked  
11 about the efficient provider or the efficient hospital in  
12 this sector, that is what has driven this formulation of an  
13 update recommendation, last year and this year, in the  
14 current construct of the recommendation. And we don't  
15 model, you know, the future projections at this level of  
16 detail but we have every expectation that the changes that  
17 we've identified in the draft recommendation would push the  
18 efficient hospital margin closer to zero, and then it could  
19 be a determination of whether or to, in a subsequent year,  
20 there needs to be additional movement in that regard.

21 So speaking only for myself, I think the  
22 efficient provider is sort of a bellwether, and we've tried

1 to contemplate what's going on with the efficient provider  
2 in a fiscally responsible way, and also in a way that's  
3 consistent with the Commission's motivation to reward value  
4 rather than general inflation.

5           MR. THOMAS: And I guess I wonder, with this  
6 chart right here, whether we ought to think about -- and  
7 maybe this is nomenclature -- whether we ought to think  
8 about that we support the total 2.8 percent increase. We  
9 just want to configure it differently and tie more of that  
10 to value-based payments. I mean, because, essentially,  
11 that's what you're doing. You're supporting the 2.8, even  
12 though you're essentially bifurcating the increase between  
13 two different areas. And I'm not sure we exactly say that  
14 in the chapter.

15           I think the other comment I would make, because I  
16 think this draft recommendation, you know, is certainly  
17 solid, there's a lot of comments in the chapter around  
18 consolidation and those types of things, and I just -- I'm  
19 not sure -- that's new information that's kind of in this  
20 chapter and it wasn't in the last chapter. I'm not exactly  
21 sure why that is new information that's there.

22           But I think the other thing I would challenge the

1 team, the MedPAC team, to look at is that hospitals are  
2 just generally better run today than they were 5 or 10  
3 years ago. They had to get more efficient. And you talk  
4 to any hospital operator and you've got a few of them  
5 around here. Jonathan works for the largest, you know,  
6 hospital operator in the country. It had to get  
7 significantly better in the last, you know, 5 to 10 years  
8 because as we're seeing more people age into Medicare it  
9 has been absolutely imperative. And as we've seen  
10 escalation in labor and drug costs it's been absolutely  
11 imperative.

12           So I think that is another component that maybe  
13 should be highlighted, of what have the improvements that  
14 have been made in how hospitals operate, how they're  
15 efficient. I think they've gotten more efficient from a  
16 staffing perspective. They've done better from a quality  
17 perspective. They've used technology differently. I'm not  
18 sure those things are highlighted, which also lead to the  
19 fact that the overall economic performance is better. I  
20 don't think it's just driven by consolidation.

21           So I would just put that out there for  
22 consideration and for potential inclusion in the chapter in

1 addition to what information is there.

2 DR. CROSSON: Thank you, Warner. I had Larry  
3 next.

4 DR. CASALINO: I think I'll save it until the  
5 next section.

6 DR. CROSSON: The next section? The next section  
7 is on physician. Oh, okay.

8 [Laughter.]

9 DR. CASALINO: [Off microphone.]

10 DR. CROSSON: Okay. Wait a minute.

11 DR. PAUL GINSBURG: Warner, yeah. Just from what  
12 you said I don't want it to get lost that this  
13 recommendation is actually supporting an increase above the  
14 -- you know, the current law, rather than equal to the  
15 current law.

16 MR. THOMAS: Well, I think part of the question -  
17 - yes, I see the 0.5 percent.

18 DR. PAUL GINSBURG: It's 3.3.

19 MR. THOMAS: Right. It's a 0.5 percent  
20 elimination. But I also look at, you know, I'm not sure,  
21 you know, when or how that modification of that, you know,  
22 quality program is going to be put in place. I understand



1 it's a recommendation, but it may or may not be put in  
2 place, and usually what's looked at is kind of the base  
3 annual update.

4           So I think it's just important to understand  
5 that. I agree with you, Paul, that it is a total increase  
6 that's over the current law. I think it's warranted, given  
7 the economic performance that we see in inpatient Medicare  
8 rates. I'm just not sure that 0.8 and the 0.5, how those  
9 come to fruition, whether they happen given their tie to a  
10 major change in the quality program that we're not sure  
11 what's going to happen with that.

12           DR. CROSSON: Okay.

13           DR. CASALINO: I think I'll ask it now and then  
14 maybe in the next session too.

15           DR. CROSSON: Ask it again.

16           DR. CASALINO: It may not be a fair question, but  
17 I'll sleep better, I think, if I ask it. If I were one of  
18 the like 600,000 or so physicians in the United States who  
19 don't understand like how MedPAC develops recommendations,  
20 and just looked naively at this session and the next one, I  
21 might ask, why are we giving a pretty generous, under the  
22 circumstances, update to hospitals, recommending a pretty

1 generation update to hospitals, and recommending nothing at  
2 all for physicians? What would the answer to that be? I  
3 have to say, if a physician asked me that, I don't know  
4 what I would say, honestly, and I'd like to know what other  
5 people would say.

6 DR. STENSLAND: I'll take a stab at that. So at  
7 least when we're looking at the hospital, there is these  
8 balances of various indicators of payment adequacy, and one  
9 of them is how do your payments compare to your costs as a  
10 hospital. And that, as Jim said, is a negative efficient  
11 provider margin. And for some of you, you might be okay  
12 with that; others might not be.

13 But what this does is it moves it up so that the  
14 payments to the hospital are going to be closer to the cost  
15 of efficiently delivering the care.

16 DR. CASALINO: We don't have a comparable  
17 analysis for physicians?

18 DR. STENSLAND: And that's in the physician, we  
19 don't have a comparable analysis, and part of that is for a  
20 lot of physician practices the biggest cost is actually  
21 their own personal income. You know, this might be half of  
22 cost might be the money going to the physician. So it

1 makes it more difficult. And there's a greater reliance on  
2 the access to care and what our surveys say in terms of you  
3 still being able to access physicians and the other  
4 metrics.

5 DR. CROSSON: Yeah. I think, you know, the other  
6 aspect of it, sort of historically, Larry, is once the SGR  
7 was repealed and Congress came in with its own new  
8 recommendations about how physicians should be paid and  
9 rewarded and the like, I think it was our sense here at the  
10 Commission that, rightly or wrongly -- and I don't know  
11 that this needs to be maintained for all time -- but I  
12 think it was our sense that we ought to give these new  
13 initiatives from Congress a time to play out before we came  
14 in and made additional recommendations. Now that was -- I  
15 don't know how many years ago was that. Three years ago?  
16 So more than that. Right.

17 So, no, I think it's a fair question to say, at  
18 least here within the deliberations of the Commission, does  
19 that default stay in place forever or not, or does it need  
20 to be reconsidered?

21 DR. MATTHEWS: Just to add two more points. One,  
22 as Jeff alluded to, we do pay a lot of attention to the

1 efficient provider in each sector where the data permit us  
2 to identify such a creature, and this is because our  
3 authorizing statute does require us to look at the adequacy  
4 of Medicare payments relative to the efficient delivery of  
5 care. And so that's why we kind of, you know, put a lot of  
6 weight on that particular measure.

7           As Jeff said, we do not have cost information on  
8 the physician sector or ASC, and so we aren't able to  
9 define an efficient provider as relatively low-cost,  
10 relative high-quality. And we default to our other set of  
11 indicators, and in the physician sector we actually one  
12 that's fairly strong, which is a direct measure of access,  
13 the beneficiary survey that we conduct every year. And it  
14 has been remarkably stable over time, and so that's the one  
15 that rises to give weight to our physician recommendation.

16           The last thing I would say is going to this  
17 notion of not increasing the differentials between settings  
18 with respect to the payment updates. Here we're at a 2  
19 percent across-the-board update for hospitals. A statutory  
20 update for physicians is zero, but for those physicians who  
21 are eligible for a MIPS payment adjustment, I want to say  
22 it's, in the aggregate, 1.88 percent, if I've got that

1 number right, this year.

2           So there is a certain parity that is maintained  
3 in the way we have set these things up.

4           DR. CASALINO: This is helpful. I just would say  
5 to the Commissioners I think we should, not just about  
6 physicians but for everybody, we should all be prepared to  
7 answer a question like, "Why are you giving maybe 3.3  
8 percent to hospitals and nothing to physicians?" We should  
9 all be able to answer that question.

10           DR. CROSSON: Yeah, thank you. Karen, on this  
11 point?

12           DR. SAFRAN: I share Larry's concern not only  
13 about answering the question but just generally about the  
14 strategy, and I would endorse that going into next year,  
15 that we revisit whether there is payment adequacy, taking  
16 into account, with all due respect to the hospitals, they  
17 have other sources of revenues that some physician groups  
18 wouldn't have, 340B programs, GME programs,  
19 disproportionate share dollars, upper payment limit  
20 dollars. So there are other ways that they're stringing  
21 together their margin, and you can see that reflected in  
22 the document, that the total margins aren't negative;

1 whereas, physicians probably have fewer levers at their  
2 disposal.

3           I would just call out, in addition to asking that  
4 next year we give some consideration to understanding  
5 better what data we would need to know, what it feels like  
6 to run a practice on the front lines given new expectations  
7 and technology and whatnot, but that in addition to the  
8 MIPS, there's some rebalancing of the fee schedule that the  
9 Medicare program is proposing, which also helps in a more  
10 nuanced way to drive the payments to a portion of the  
11 physician workforce and clinician workforce where we really  
12 want to make sure that they're receiving appropriate  
13 reimbursement for the services, primary care in particular.

14           So there are some changes, I think, that are  
15 underway in the next couple of years, but I would endorse  
16 the idea that, going forward, we should reopen that concept  
17 of flat update and see if it's time to reconsider it.

18           DR. CROSSON: Okay. Jaewon, on this point or a  
19 separate point?

20           DR. RYU: Sort of.

21           DR. CROSSON: Sort of on this point, okay.

22           DR. RYU: So at the risk of dragging us into

1 Round 1, I did have a couple clarifying questions in light  
2 of Warner's comments, so that's why it's "sort of." What  
3 would happen -- if the HVIP didn't go forward, what would  
4 happen to that 0.8? What do we contemplate?

5 DR. CROSSON: Current law.

6 DR. STENSLAND: So if the HVIP doesn't go into  
7 place, there's no like backup recommendation. If our  
8 recommendation is not accepted, then it would be current  
9 law, and you would have -- current law would govern, and  
10 there would be a 2.8 percent increase.

11 DR. RYU: And sort of related to that, the 0.8  
12 that we're proposing would go into the HVIP, would that  
13 just go -- it would be an incremental amount that would  
14 enter into the HVIP pool? Is that how we're envisioning  
15 it?

16 DR. STENSLAND: Right. So you would have this --  
17 you have a budget-neutral HVIP to start with. Then you  
18 have an extra 0.8 percent on top of it. So in the end,  
19 there would be a little bit more paid out in HVIP bonuses  
20 than the hospitals put in.

21 DR. RYU: So what was the -- I forget what the  
22 withhold amount was that we were envisioning within HVIP.

1 Was it 5 percent or 2 percent?

2 DR. STENSLAND: We had talked starting at 2.

3 DR. RYU: It was 2. So now it would be -- now we  
4 should think of it as 2 plus an extra 0.8?

5 DR. STENSLAND: Ledia?

6 MS. TABOR: Yes, we started with 2 going up to 5  
7 so it would be 2.8 [off microphone].

8 DR. RYU: Okay.

9 DR. STENSLAND: And then don't forget the other  
10 aspect of this is the current quality programs are a net  
11 penalty, so those net penalties would go away, which in  
12 essence you start -- you're going from a negative 0.5 to a  
13 positive 0.8 on average.

14 DR. CROSSON: Jon.

15 DR. PERLIN: Thanks for this discussion. Let me  
16 start by saying that I generally support the  
17 recommendation. But I do think that I want to associate  
18 with Warner's comments here. I think how we articulate  
19 what we articulate is very important. I think there are a  
20 number of threads that have come up along this.

21 You may recall last time I asked exactly the  
22 clarifying question Jaewon just asked about HVIP that's



1 statutory, and given that it's statutory, the likelihood,  
2 at least if I had to handicap this, of this being enacted  
3 to change before the next fiscal year I think is slim.

4           With that in mind, I'd ask for just clearer  
5 language. I know it's the default, I know it's the law,  
6 but just that there be clearer language about the update.  
7 When you talk about a 2 percent withhold and then 0.8,  
8 you're talking about flat, and that's where I begin to get  
9 a little bit worried.

10           So if you go to page 40 in the reading materials,  
11 it says, "Hospitals under financial pressure tend to have  
12 lower costs." I'd just ask us to consider, what do we  
13 think that means? If I were to say outside of that context  
14 restaurants under financial pressure tend to have lower  
15 costs, what would you think? You'd probably say, "I'm  
16 worried. What's going on there?"

17           When you kind of put that right next to the part  
18 on consolidation, you know, we run into very few hospitals  
19 under fiscal pressure that really want to merge. What they  
20 want is to maintain their identity. What they want is to  
21 be able to serve their clientele. Hospitals under fiscal  
22 pressure don't stop seeing Medicare patients. They close.

1 And the closure rate doubled in this past year, and so I  
2 think we have to examine what the implications are of  
3 hospitals under fiscal pressure tend to have lower costs.  
4 I think it would be -- it's concerning. I think they tend  
5 to have lower costs, in fact, because certain things aren't  
6 happening, and they don't have the capital to invest in the  
7 things that would actually give them greater efficiency  
8 because those technologies are expensive. So as a large  
9 hospital operator, when distressed hospitals tend to seek  
10 us out, what are they desperate for? They're desperate for  
11 the sorts of investment, capital and operating, that can  
12 help them implement the technologies and the personnel and  
13 the systems to actually develop efficiencies to be  
14 competitive in the world. Otherwise, it's really a death  
15 spiral.

16           So I just come back to the notion as I said at  
17 the outset, I generally support this. I think it's a more  
18 rational process. I think we need to take stock of the  
19 realities of the political process which is superimposed.  
20 But I think we also need to sort of step back and  
21 understand the context of pressures this creates. Thanks.

22           DR. CROSSON: Dana, Sue, Amol.

1 DR. SAFRAN: So I appreciate this conversation,  
2 and I generally support the recommendation, but it does  
3 strike me that we have to find a way as a Commission to  
4 move forward so that hospitals are part of the  
5 accountability for total cost of care that we've begun to  
6 create in the physician community. And I think that we  
7 are, through this recommendation and through our policy in  
8 general, continuing to enable the foot in two canoes and  
9 for hospitals in particular to really continue to thrive  
10 largely on fee-for-service revenue, not on accountability  
11 for helping to manage the total cost of care. And so, you  
12 know, obviously at this hour we can't accomplish that. We  
13 need to make a decision for a policy recommendation, and so  
14 I do support moving ahead in the way that we've outlined  
15 here. But it just does strike me from this conversation  
16 that this is something that we can't ignore going forward.

17 DR. CROSSON: Dana, this is a comment you've made  
18 before and I fully agree with, and we've taken it to heart.  
19 And as we get into the spring and we're talking about the  
20 larger strategic view of the Commission and how we get to  
21 where you're deciding to go, the issue of how hospitals  
22 should be paid in the future is centerpiece to that. So

1 thank you for that.

2 Now I'm lost. Sue.

3 MS. THOMPSON: I'll be brief because I know time  
4 is of the essence. I agree, Dana, totally agree with what  
5 you just said, and Jay's comments. But I am also in  
6 support of these recommendations, so my comments are really  
7 around commentary in the document that relates to hospital  
8 closures. All good, but all very, very important and all  
9 very real to the beneficiaries.

10 To illustrate that, where I choose to live, I am  
11 12 miles from the closest critical access hospital. It's  
12 under a lot of financial stress. The second closest is 34  
13 miles. If I would need an angioplasty, I'm 54 miles, so I  
14 depend upon one of these two critical access hospitals to  
15 survive. So I can either get on a helicopter or be  
16 transported quickly to get into Des Moines, because I'm an  
17 hour away. That's very real in terms of what we're facing  
18 in terms of hospital closures in this country, and I  
19 anticipate we're going to see more. It has accelerated, as  
20 your paper supports, in the last two years, and keeping an  
21 eye on that is critical. So just a comment again about  
22 that set-up material. So thank you for that.

1 DR. CROSSON: Okay. Thank you, Sue. Amol.

2 DR. NAVATHE: So I also just wanted to voice  
3 support in general for the recommendations. First, I think  
4 certainly there's a lot of changes going on. I think I  
5 also echo Dana's comments. You know, we also know in  
6 general that there's a shift. We talked about this in the  
7 context of implications for IME and other things from the  
8 inpatient to the outpatient, how care itself is evolving.  
9 Care for how probably the way that beneficiaries want to be  
10 cared for is also evolving, so I think we should keep that  
11 in mind as well.

12 And I think Jon's point is a good one, however,  
13 which is that we should be mindful around the language  
14 that's used, and I think if we look across all the  
15 different stakeholders that we end up having to touch  
16 through the Commission's payment updates and other  
17 programs, we should create a consistency in terms of, you  
18 know, holding all sectors, all stakeholders to the same  
19 standard in some sense. And I think there is, I think,  
20 accountability and fiscal discipline. I think we generally  
21 understand that those are very important and they do spur  
22 cost efficiencies, and that's good in the long run for the

1 solvency of the Medicare program. It's good for the  
2 taxpayer; it's good for the beneficiary. But I do think  
3 that if we can institute some sort of consistency around  
4 how we present that as we go from sector to sector, that  
5 probably would be a good thing for us to do just to sort of  
6 espouse a very common way of viewing each group.

7 DR. CROSSON: Pat and then Bruce.

8 MS. WANG: So just on this theme, I agree with  
9 the importance of thinking through as we try to move to a  
10 more value-based system how to help hospitals feel that  
11 that is a system in which they can succeed. And so part of  
12 it is to stop doing certain things, and, you know, Dana's  
13 point she made clearly. But I think that we -- just a  
14 reminder that we should also be aware of, as Karen put it,  
15 there are a lot of programs in Medicare that hospitals use  
16 to stitch together a margin, and some of that keeps them  
17 rooted in the current system. So DSH is tied to inpatient  
18 statistics. You've heard me say this a million times. GME  
19 is paid to inpatient statistics. And I think that while  
20 we, you know, hold hospitals' feet to the fire to kind of  
21 get with what's happening in the country and in the world,  
22 we need to also take the responsibility to remember that

1 there's just a lot of stuff in the current Medicare system  
2 that has built up over time and it's just all still there  
3 that we need to think about changing to relieve some of the  
4 -- I mean, in some ways the way that Medicare is designed  
5 today anchors a hospital's foot in that other canoe. And  
6 so in addition to telling them you have to get with the  
7 program, you have to get into the Ferrari, I think we have  
8 to be mindful of the things that need to be loosened up so  
9 that people can change more easily when they have the will,  
10 because I think many places do really have the will.

11 DR. CROSSON: So, I mean, I agree. I think  
12 taking on the question of how hospitals are paid and what's  
13 included, the things you mentioned and others, is central,  
14 I think, to the mission that we're on here. I think it's  
15 going to be one of the heaviest lifts that this Commission  
16 has ever attempted, but I think it's something -- as I've  
17 said before on several occasions, it's something we have to  
18 do.

19 I had Bruce and then Warner.

20 MR. PYENSON: I just want to pile on to -- I  
21 guess Larry started the chain and then Karen and Dana. But  
22 I hope to feel better about this a year from now for the

1 reason -- and, you know, Pat has added to that. I can  
2 think of a number of accounting kinds of issues -- and Pat  
3 alluded to them -- that would help get us there. And I  
4 know it's a heavy lift. It's probably easier than Part D.

5 [Laughter.]

6 DR. CROSSON: Okay. I'm not sure if that's a low  
7 bar or a high bar. Warner.

8 MR. THOMAS: Yeah, just a couple of comments.

9 So, generally, I can support the recommendation as well. I  
10 think Jonathan's point about indicating that if this new  
11 quality program is not put in place, then the 2.8 ought to  
12 be the recommendation.

13 I think also, you know, perhaps instead of  
14 putting these dollars towards quality programs or maybe  
15 they go that direction but they're only eligible for  
16 organizations that are in alternative payment mechanisms,  
17 like the ACO models or that evolved into risk or that sort  
18 of thing, because I think -- I agree with you, Pat. I  
19 think we do need to get organizations kind of moving down  
20 that path, and it's going to take financial incentives to  
21 get that done.

22 I'd also say the same thing on physicians. I



1 mean, essentially every time we've got to make any sort of  
2 physician change, it's still in kind of the fee-for-service  
3 mode. And we should probably put more dollars in that  
4 model, pushing them towards alternative payment mechanisms,  
5 and into, you know, partial risk or risk type arrangements.  
6 So I think putting more dollars in those areas would be  
7 smart for the Commission and for the program long term.

8           I would just say on the comment about why  
9 hospitals, not physicians, I think if we were sitting here  
10 having a discussion about physicians losing 10 percent on  
11 Medicare patients, we'd probably be doing a pretty big  
12 increase for them as well, if not more, because, frankly,  
13 physicians probably would stop, especially independent  
14 physicians would stop seeing Medicare patients if they had  
15 that type of loss, you know, from seeing that patient.

16           Now, luckily, today that's not necessarily the  
17 case, but I think the recommendation is good, I think with  
18 those couple of modifications that Jonathan talked about.  
19 I think that would be helpful. And I do think we ought to  
20 have verbiage in the chapter indicating that maybe there  
21 should be more dollars that are put towards organizations  
22 that are willing to go down the road of ACO models or other

1 alternative mechanisms, especially if we don't think some  
2 of the quality programs are going to be adopted. Maybe we  
3 should kind of, you know, target it in a different way. So  
4 just another idea.

5 DR. CROSSON: Okay. So just to be clear, if this  
6 entire recommendation is not picked up by the Congress, it  
7 will then default to the 2.8 percent.

8 MR. THOMAS: I understand, but I also think being  
9 clear that -- I understand it's the default, but I think  
10 being clear that we understand that if this part of the  
11 recommendation that's being put forward is not adopted,  
12 then we certainly would support the 2.8. We think it's  
13 adequate; we think it makes sense. I think maybe I'm -- I  
14 know you're reading between the lines, but I think being  
15 clear about it would be helpful to the reader of the  
16 chapter.

17 DR. CROSSON: And we can put that in the text.

18 MR. THOMAS: Yeah, exactly.

19 DR. CROSSON: To be frank, if it defaulted to 2.8  
20 percent, that's less than what we've recommended, but we  
21 can say it's -- however you'd like to couch that.

22 MR. THOMAS: Yeah. I would also just echo

1 Jonathan's point around, you know, hospitals do not want to  
2 merge with other large organizations. They do not want to  
3 do that. They do it out of absolute financial need. So I  
4 do think that would be a component that should be  
5 compelling, and it's why you see organizations hold on as  
6 long as possible so that if they do do a merge -- and many  
7 of them are in very difficult economic situations because  
8 they do not want to do this. So if you read this chapter  
9 and you think about, well, that's what everybody's doing,  
10 and they're just doing it for economic reasons. They're  
11 doing it out of survival reasons. I'm not saying that's  
12 every single transaction out there, but many of them are  
13 out of absolute financial necessity.

14 DR. CROSSON: Okay. Thank you, Warner.

15 Seeing no further comments, the draft  
16 recommendation is before you. All Commissioners who wish  
17 to approve the draft recommendation, please raise your  
18 hand.

19 [A show of hands.]

20 DR. CROSSON: All opposed?

21 [No response.]

22 DR. CROSSON: Abstentions?

1 [No response.]

2 DR. CROSSON: Seeing none, it passes unanimously.

3 Thank you, Jeff, Stephanie. We'll move on to the  
4 next presentation.

5 [Pause.]

6 DR. CROSSON: Okay. Discussion and  
7 recommendation is on the adequacy of payments to physician  
8 and other health professionals. Rachel, Ariel, and Brian  
9 are here, and, Rachel, it looks like you're going to start  
10 off.

11 MS. BURTON: Good afternoon. In this session,  
12 we'll summarize our assessment of the adequacy of payments  
13 for physician and other health professional services.

14 We'd like to thank Ledia Tabor, Kevin Hayes, and  
15 Carlos Zarabozo for their contributions to this analysis.

16 We'd also like to note that the version of our  
17 physician update chapter that Commissioners were sent in  
18 advance of today's meeting reflects revisions made in  
19 response to Commissioner comments at our December meeting.

20 Fee-for-service Medicare pays for services  
21 provided by physicians and other health professionals using  
22 a fee schedule. In 2018, total spending for clinician

1 services was about \$70.5 billion, or 17 percent of Medicare  
2 fee-for-service spending. About 1.2 million clinicians  
3 billed Medicare's fee schedule in 2018.

4           In 2021, current law calls for no update to  
5 clinicians' base payment rates, but clinicians can receive  
6 an adjustment ranging from minus 7 percent to plus 7  
7 percent if they are subject to the Merit-based Incentive  
8 Payment System, or MIPS. Clinicians covered by MIPS can  
9 also receive an extra payment increase for exceptional  
10 performance, if they meet certain thresholds.

11           Alternatively, clinicians substantially  
12 participating in an advanced alternative payment model, or  
13 A-APM, can receive an annual lump sum incentive payment  
14 worth 5 percent of their total professional service  
15 billings. So far, about a million clinicians received  
16 additional payments in 2019 and in 2020  
17 through positive MIPS adjustments or A-APM bonuses.

18           According to multiple indicators, Medicare  
19 beneficiaries have good access to care. In our 2019 phone  
20 survey, most beneficiaries reported no trouble getting  
21 appointments and described access that is similar to,  
22 or better than, privately-insured individuals near

1 retirement. We saw similarly positive access-to-care  
2 indicators in the 2017 Medicare Current Beneficiary Survey.

3           Using claims, we found that from 2013 to 2018,  
4 the number of clinicians billing the Medicare fee schedule  
5 has grown faster than the number of beneficiaries in the  
6 Medicare program.

7           We also found that the number of clinician  
8 encounters per beneficiary grew by 1.5 percent from 2017 to  
9 2018.

10           And, finally, we found that 99.6 percent of  
11 clinicians' Medicare fee schedule claims were paid on  
12 assignment, which means clinicians accepted Medicare  
13 payment rates as payment in full and did not balance-bill  
14 beneficiaries.

15           Our findings on quality are more mixed.  
16 According to CAHPS data, beneficiaries rated their care  
17 quality an 8.5 out of 10 in 2018 and rated the Medicare  
18 fee-for-service program an 8.3 out of 10, consistent with  
19 prior years' ratings.

20           But there was wide geographic variation in the  
21 rates of ambulatory care-sensitive hospitalizations and ED  
22 visits, with rates twice as high in some hospital service

1 areas as others. This signals opportunities for clinicians  
2 to improve the ambulatory care they deliver so they can  
3 prevent beneficiaries from needing to use the hospital.

4           Next, we found that providers' payments and costs  
5 are both rising somewhat. Physicians all-payer compensation  
6 continues to rise.

7           Medicare payments per beneficiary have increased  
8 over time by about 1 percent per year on average from 2013  
9 to 2017 and by 2.3 percent from 2017 to 2018.

10           Private insurers continue to pay clinicians  
11 higher rates than Medicare, which may be due to increased  
12 provider consolidation.

13           In 2018, private PPO rates were roughly stable at  
14 135 percent of Medicare's rates, up only slightly from  
15 2017.

16           Clinicians' input costs, as measured by the MEI,  
17 are increasing and are expected to grow by 2.6 percent in  
18 2021.

19           In addition to these puts and takes, about a  
20 million clinicians also received additional payments  
21 through positive MIPS payment adjustments or A-APM bonuses  
22 in 2019 and 2020. Most of these clinicians received

1 positive MIPS adjustments, which means their payment rates  
2 were increased by up to 1.9 percent in 2019 and by up to  
3 1.7 percent in 2020.

4           In contrast, only about 50,000 clinicians  
5 received negative MIPS adjustments in 2019, and that number  
6 fell to 18,000 in 2020.

7           Many clinicians have already figured out how to  
8 do well on MIPS measures, since their median score in 2020  
9 was 99.6 points out of 100, up from 89 points in 2019.

10           The number of clinicians qualifying for 5 percent  
11 incentive payments because they participate in an A-APM is  
12 smaller but is growing. So although current law specifies  
13 that clinicians receive no update to their base payment  
14 rates, they do receive additional payments through MIPS  
15 adjustments or A-APM bonuses.

16           Based on the preponderance of our indicators,  
17 which include very strong access-to-care indicators, we are  
18 concluding that a current law update is warranted. In  
19 particular, despite Medicare paying lower rates than  
20 commercial plans, Medicare beneficiaries enjoy access to  
21 care that is similar to, or better than, commercially  
22 insured individuals near retirement.



1           Our draft update recommendation therefore reads,  
2 "For calendar year 2021, the Congress should update the  
3 2020 Medicare payment rates for physician and other health  
4 professional services by the amount determined under  
5 current law."

6           In terms of implications, there would be no  
7 change in spending compared with current law, and this  
8 update should not affect beneficiaries' access to care or  
9 providers' willingness or ability to furnish care.

10           This concludes our presentation. We're happy to  
11 take questions.

12           DR. CROSSON: Thank you, Rachel.

13           We'll now have clarifying questions. Larry?

14           DR. CASALINO: You all made quite a bit about the  
15 MIPS payments to physicians in the presentation. This is a  
16 budget-neutral, basically. So if very few physicians, as  
17 you mentioned, are getting penalties and almost everyone is  
18 getting bonuses, it must mean that bonuses are quite small?

19           MS. BURTON: Yes.

20           DR. CASALINO: That could be clearer, I think,  
21 because the way the presentation sounded, at least to me,  
22 was, okay, physicians won't get any update, but don't

1 worry, they're getting MIPS payments. The MIPS payments  
2 are pretty small, I think.

3 MS. BURTON: It is up to 1.7 percent in --

4 MR. WINTER: And I just want to point out they  
5 are getting -- for six years, they will be getting \$500  
6 million per year. That's in exceptional performance  
7 bonuses that are not budget-neutral. That's over and  
8 above, and that's why the highest, the maximum increase is  
9 1.7 percent in 2020. Whereas, the maximum penalty is much  
10 less than that.

11 Also, the 5 percent bonuses for advanced APM  
12 participants is also not budget-neutral. That's over and  
13 above the money that's in the base.

14 DR. CASALINO: The exceptional performance is  
15 included in the 1.7 percent, you were saying?

16 MS. BURTON: Yes.

17 DR. CASALINO: Okay. Oh, yeah, I didn't  
18 understand this. That would be great to make that clear.  
19 Otherwise, the straight MIPS without the exceptional  
20 performance would be right now less than the 1 percent.

21 MS. BURTON: It would be like 0.2 percent. It  
22 would be very low.

1 DR. CASALINO: Okay. Yeah, that probably would  
2 be good to have in there.

3 DR. CROSSON: Yeah. I just want to make one  
4 point. Just to be clear, it was the projection of this  
5 Commission based on staff work that what is currently  
6 playing out was, in fact, going to play out, and it's one  
7 of the reasons that we suggested relatively early on that  
8 the MIPS program needed to be replaced with something else.

9 Amol?

10 DR. NAVATHE: So it's my understanding, at least  
11 in the earlier years of MIPS, that the predominant metric  
12 was essentially based on reporting measures as opposed to  
13 performance in measures. So when you're citing the 2020  
14 numbers here, how much of that is reflecting reporting  
15 purely versus actual, quote, "performance"?

16 MS. BURTON: I don't have a specific answer for  
17 you, but in general, you're correct that in the early  
18 years, it's more just reporting as opposed to performance.  
19 And I can get back to you with something more specific.

20 DR. CROSSON: Clarifying questions?

21 Yeah, Marge.

22 MS. MARJORIE GINSBURG: I just wanted a better

1 sense of what we're talking about when we're talking about  
2 1-point-something percent increase in physician  
3 compensation.

4           So I realize physician compensation varies,  
5 depending on region and depending on what type of physician  
6 they are. We're talking about all levels and all -- but  
7 your typical, can you give us an example of a typical PCP  
8 in a typical Midwestern city? What are we talking about  
9 here, and what is the range?

10           I mean, 1-point, whatever it was, percent doesn't  
11 sound very high to me, and I just wanted to get a better  
12 sense of what it means.

13           MR. WINTER: I'm just trying to understand the 1  
14 percent. What are you referring to?

15           MS. MARJORIE GINSBURG: Okay. So we are talking  
16 about the increase in physician fee schedules.

17           MR. WINTER: Okay.

18           MS. MARJORIE GINSBURG: And I thought I heard  
19 reference that what we're now looking at is the possibility  
20 -- I mean, I'm sorry. I'm blanking on the number, but the  
21 percent increase that is --

22           DR. CROSSON: 1.7 percent.

1 MS. MARJORIE GINSBURG: Thank you.

2 1.7 percent.

3 MR. WINTER: Oh, under MIPS, the maximum increase  
4 under MIPS.

5 MS. MARJORIE GINSBURG: Yes.

6 MR. WINTER: Okay.

7 MS. MARJORIE GINSBURG: Okay. So I just want to  
8 get a sense of what that actually represents in real  
9 dollars --

10 MR. WINTER: I see.

11 MS. MARJORIE GINSBURG: -- for an individual  
12 physician.

13 MR. WINTER: Right. So to do that, we would need  
14 to look at kind of median -- or mean physician, Medicare  
15 physician revenue -- Medicare physician fee schedule  
16 revenue for a physician. I don't have that handy. We'd  
17 have to do probably some calculations to get that for you.

18 It sounds like you're also asking about kind of  
19 typical all-payer compensation. We have that information  
20 in the chapter, and I can give you some of that, some of  
21 those numbers, if you would like now.

22 MS. MARJORIE GINSBURG: I guess part of my

1 interest, we know hospitals are running a deficit if  
2 they're relying only on Medicare patients, and they stay  
3 alive because they have commercial patients. Is that true?  
4 Is the same thing true for the average physician? How many  
5 commercial patients do they have to have to balance out  
6 their Medicare income to give them what one might consider  
7 a reasonable income?

8 DR. CROSSON: Let me just point out, Marge, that  
9 that last few words was kind of central to the conundrum  
10 that we have, which is at least we think we understand that  
11 with respect to institutional payments or most of the other  
12 areas of reimbursement we're going to be dealing with  
13 today, we have some data that can indicate what the costs  
14 are. Now, whether the cost is the right level of cost is  
15 another question, but we can look at cost. And we can look  
16 at revenue or income, and we can say is it too much or too  
17 little.

18 As Jeff pointed out in the previous session, that  
19 with respect to individual physicians -- let's look at it  
20 that way -- a significant portion, 50 percent or more of  
21 practice costs for the physician is the personal income for  
22 the physician. And so just as you said what's a reasonable

1 income, that's an issue -- an absolute reasonable income is  
2 an issue that we've not engaged in, and we don't exactly --  
3 I don't know how we could do that.

4           To the extent that we've engaged in this issue at  
5 all, it has been on the issue of relative income, and the  
6 problem that has been created by the relative payment rates  
7 and the impact that that is having on the -- at potential  
8 adequacy of primary care services for Medicare  
9 beneficiaries.

10           But to kind of answer the question of what is a  
11 reasonable income for a particular specialty is not  
12 something I think we can do.

13           Yeah. Jim?

14           DR. MATHEWS: Yeah. Just to add two points that  
15 might help how you think about this, Jay is, well --

16           DR. CROSSON: You can say I'm right. Go ahead.

17           DR. MATHEWS: That's exactly what I was going to  
18 say, so since you said it --

19           [Laughter.]

20           DR. MATHEWS: A couple of things. Each year, we  
21 look at the relationship between Medicare payments to  
22 clinicians under the fee schedule relative to commercial

1 payment rates, and it has been relatively stable over time.  
2 And I think our most current metric is that commercial  
3 rates are about 135 percent of Medicare, and that ticked up  
4 a point from last year.

5           There's been a little bit of an erosion over time  
6 but reasonably steady. So that's one metric that we do  
7 year after year that might help you think about physician  
8 compensation.

9           The second is something that we have done in the  
10 past, and I don't think we have done this routinely year  
11 after year, but several years ago, we went through an  
12 exercise where we modeled what physician total compensation  
13 would be if they were paid for all of their business under  
14 the Medicare fee schedule. We did do this, correct?

15           MR. WINTER: Yeah. And most recently, like 2014  
16 or '15. So it's been several years.

17           DR. MATHEWS: Right. And so I cannot recall  
18 specifically what the numbers were, but they were portrayed  
19 in one of our report chapters. And you can see what kind  
20 of income would pertain to a physician if they were paid  
21 entirely at Medicare rates, and in terms of whether or not  
22 that represents a reasonable income, I won't opine. That's



1 up for you to decide, but we've done those kinds of  
2 analyses in the past that at least indirectly bear on your  
3 question.

4 MS. MARJORIE GINSBURG: Just drawing a comparison  
5 to disproportionate share hospitals, has it ever been  
6 broached that we look at disproportionate share physicians  
7 who take more than their fair share of patients with lower  
8 compensation?

9 DR. CROSSON: Well, to a large degree -- I'm  
10 talking off the top of my head now, which is all right, I  
11 guess. Well, I'm going to hold that comment because I have  
12 to think more about how to answer that. Sorry.

13 DR. DeSALVO: You know, the system may think that  
14 it has a solution to that, Marge, in the federally  
15 qualified health center program, where there's an  
16 opportunity for off-site compensate.

17 DR. CROSSON: Yeah.

18 Jon? Jonathan?

19 DR. JAFFERY: Yeah. Just one or two quick points  
20 with respect to this. So one is that the 134 or 135  
21 percent of Medicare rates is a national average, right? So  
22 there's just quite a little bit of variability --

1 MR. WINTER: Yes, definitely.

2 DR. JAFFERY: -- across the country.

3 MR. WINTER: And by service.

4 DR. JAFFERY: Yeah. And I think most of the  
5 studies that I've seen that try to get at some of the  
6 variability have been a little bit challenged by not having  
7 tons of complete data limited to maybe a couple of the big  
8 payers. It may still be helpful if you try to see the  
9 scope of variability but may not help with a particular  
10 region.

11 Then just in a separate thought, I'm thinking  
12 about we've had conversations not that long over the past  
13 few months where -- or at least a conversation about  
14 geriatricians, and there's a population that certainly is  
15 predominantly get paid, sees Medicare patients, so  
16 something to think about.

17 DR. CROSSON: And are disappearing.

18 Jon?

19 DR. PERLIN: Yeah. This is on Marge's point.  
20 I've honestly forgotten whether we are in Round 1 or Round  
21 2.

22 DR. CROSSON: Well, we are in Round 1.5. We'll

1 give you some latitude here.

2 DR. PERLIN: Thanks.

3 That's about perfect for this. We examine  
4 hospitals and physicians as if they are completely  
5 independent, but in the real world, they're really not.  
6 Because of payment rates, the physicians, if anyone here  
7 has in any way been involved in running a hospital, show me  
8 a hospital service and emergency service where there are  
9 really hospital-based physicians that aren't subsidized in  
10 a way that kind of bolsters what would not be tenable to  
11 have those physicians seeing patients at the facility based  
12 on Medicare rates alone. So I'd just note that there's an  
13 interplay there that I think we have to be sensitive to.

14 It probably gets back to the larger point that we  
15 need to think more broadly and in the aggregate about how  
16 these things operate together and how they're compensated  
17 together.

18 DR. CROSSON: Okay. So we've sort of drifted out  
19 of 1 into 2, so go ahead, Larry.

20 DR. CASALINO: This is actually a clarifying  
21 question. Help me out with the cost a little bit. In the  
22 last session, it was pointed out that we probably know more

1 about hospital costs, and we know little or nothing about  
2 physician costs, which was pretty much what I thought. But  
3 you do have a slide here that showed, if I added it  
4 correctly, about a 5.8 percent increase in MEI, the input  
5 cost for physician practices over the last three years. So  
6 that's some knowledge about costs, right? Or one could say  
7 5.8 percent input cost but no update over that same -- no  
8 payment update for physicians who aren't in an A-APM over  
9 those three years. Is that a correct statement?

10 MR. WINTER: Yeah. This is a price index  
11 developed by CMS, and as we talked about last time, the  
12 cost rates at least are based on fairly old data, from  
13 2007, 2008, but the price data are updated annually. But  
14 if you think the cost rates are out of date, then you might  
15 have some questions about whether this is still accurate or  
16 not. But it is the best data source we have, and so given  
17 all these qualifiers, that is the best estimate of cost, of  
18 increases in cost inputs for physician services.

19 DR. CASALINO: Are physician salaries included in  
20 that or just rent and staff and things like that?

21 MR. WINTER: It includes physician compensation -  
22 -

1 DR. CASALINO: It does.

2 MR. WINTER: -- as well as nonphysician staff  
3 compensation, and those two components are the bulk of the  
4 cost, about two-thirds.

5 DR. CROSSON: So the only point I'd make in  
6 addition is we're going to get to this, I think, in a  
7 minute or two, but in terms of how MACRA was constructed,  
8 there was an intentionality on the part of Congress to  
9 create a gradient in payment updates or rewards towards A-  
10 APMs, you know, which carries with it, for successful ones,  
11 based on our policy, a 5 percent bonus.

12 So I think it's -- we're going to get to this  
13 towards the end, but I think I agree with Karen that maybe  
14 enough time has elapsed now since we first said let's wait  
15 and see how this is working out, with respect to the  
16 adequacy of payments for us to come back and say, okay,  
17 maybe now is the time to take a harder look at that.  
18 But I don't want us to lose the fact that Congress, in  
19 their wisdom when they created this, purposely created a  
20 gradient token to try to get physicians, for the reasons  
21 we've talked about, try to get physicians involved in  
22 payments systems that are more based on managing the costs

1 and quality of the population.

2 DR. CASALINO: And can I build on that in  
3 relation to part two?

4 DR. CROSSON: I'd be pleased if you did that.

5 DR. CASALINO: So, no, I understand what you just  
6 said, Jay, and it's a good point. Building on what Warner  
7 said in the last session, I think, so basically Congress  
8 said to physicians, and I agreed with this, was if you want  
9 to keep on as you are, you can, but you're not going to get  
10 a payment increase for five years or so. You might from  
11 MIPS but you won't get a regular rate increase. But if you  
12 want to get into one of the new advance payment models,  
13 we'll give you an automatic 5 percent each year. So, you  
14 know, I think that was a reasonable policy.

15 But I think Warner -- and he didn't say it in  
16 these words -- but in effect pointed out we haven't done  
17 the same thing for hospitals. And it would be possible to  
18 say you don't get an update unless you're an X model, or  
19 you don't get a bonus unless -- whatever.

20 But actually that's not something I've heard  
21 discussed. I don't mean just here, but maybe it has been  
22 discussed here but I haven't heard it. But it could be,

1 you know, going forward, we could think along those terms.  
 2 But why would one do it, with one important component of  
 3 the delivery system and not with a much bigger component,  
 4 really, in terms of dollars spent.

5 DR. CROSSON: And I think we -- aside from the  
 6 global discussion about let's fix hospital payment, I think  
 7 we've been trying to move in that direction by holding  
 8 hospitals accountable for the per-Medicare beneficiary  
 9 expenditures. It's a small amount but that's in there.  
 10 And I think we weighted -- did we weight that more than the  
 11 others? I can't remember?

12 MS. TABOR: [Off microphone.]

13 DR. CROSSON: It's not a weighted model. Okay.  
 14 But it's a start.

15 DR. JAFFERY: Just a quick comment in response to  
 16 what Larry said. Just to clarify that the differential  
 17 payment, it goes -- I don't think I can say this -- so  
 18 after the time when the advanced APM bonus payments end in  
 19 2026, 2025 --

20 MR. WINTER: '24 is the last year that they will  
 21 be paid, yeah. 2025 -- after 2024 they stop.

22 DR. JAFFERY: Okay. So thanks. And it's after

1 that, if you're in an advanced APM model you get the  
2 physician incurring lots of points, 7.5?

3 MR. WINTER: Well, there's one year but there's  
4 no update for any clinicians. That's 2025. And then in  
5 2026, there is a differential update for clinicians in  
6 advanced APMs. They get 0.75, and all of the clinicians  
7 get 0.25 percent update?

8 DR. JAFFERY: When would then presumably compound  
9 over time.

10 MR. WINTER: Yes.

11 DR. JAFFERY: So, to me, that's the bigger  
12 differential that pushes people in the out years more and  
13 more towards advanced APMs, as opposed to what we have  
14 through 2024, in some ways anyway.

15 DR. CROSSON: Okay. So we are sort of in Round  
16 2. Kathy. Feel free.

17 MS. BUTO: Right. I've been waiting for that. I  
18 just wanted to say that all these updates we're talking  
19 about are really updates to fee-for-service payments.

20 DR. CROSSON: Yes.

21 MS. BUTO: And we call them A-APMs but they're  
22 really ACOs, aren't they, mostly?



1 DR. CROSSON: Mostly.

2 MS. BUTO: And ACOs are fee-for-service, although  
3 they are fee-for-service with incentives to do more  
4 coordination of care. So I'm really glad Karen brought up  
5 the idea of revisiting the way we pay physicians. I hope  
6 since it won't happen in this go-around that you'll  
7 consider doing some of what I think Warner was getting at,  
8 which is arrangements, even within the ACO or A-APM, that  
9 go to things like partial capitation.

10 We've talked about trying to increase incentives  
11 for primary care physicians. We've mainly talked about  
12 increasing their payment rates, and not changing the  
13 arrangements, giving them more flexibility, partial  
14 capitation, whatever the combination is. And I think the  
15 Commission could be a little more creative in that space,  
16 beyond just increasing rates, which is, I think, even in  
17 this chapter we talk about CMS's effort to increase the E&M  
18 code payments.

19 So I love it, but I really hope -- I think the  
20 next step is a bigger step than the one we've been taking.

21 DR. CROSSON: I completely agree with that,  
22 although I would point out, a little bit, we did try to do

1 this with primary care, and our recommendation was  
2 basically a partial capitation.

3 MS. BUTO: Right. It was a fairly small amount.

4 DR. CROSSON: It was small.

5 MS. BUTO: I think we could be more ambitious.

6 DR. CROSSON: Right.

7 DR. DeBUSK: On that, first of all, I totally  
8 agree. I'm glad we're -- I know this is the updated thing,  
9 and I'm sure like Jay and Jim are going nuts that we're  
10 talking about this and not voting on an update. But I  
11 completely agree. Talking about hospitals are paid and how  
12 physicians are paid is a central theme that I hope we do  
13 this spring and I hope we carry it on.

14 To your point, I think the primary care incentive  
15 bonus -- Jay, you mentioned it -- is fantastic. The one  
16 thing is it didn't have any -- it didn't have a lot of  
17 volume in it. It was a relatively small payment.

18 DR. CROSSON: Right.

19 DR. DeBUSK: I think if you were -- and I'm going  
20 to go out on a limb -- but if you were looking at the real  
21 risk involved in the patients that are in the panel, some  
22 type of management, some type of medical expense ratio,

1 where the groups that were managing these patients well  
2 were getting fairly large bonuses, I mean 20, 30, 40  
3 percent of their compensation could be up to that. It  
4 could be through how they manage through this medical  
5 expense ratio. You could put more money in the primary  
6 care incentive bonus if you tiered it based on performance  
7 instead of turning it into something that everyone who  
8 meets a certain, you know, E&M mix or identifies as a  
9 certain specialty qualifies for.

10               So there's a way to do a qualified primary care  
11 incentive bonus that would have a lot more money in it.

12               MS. BUTO: I'm glad you're going to be here to do  
13 this, Brian.

14               [Laughter.]

15               MS. BUTO: I'm excited. The other thing I'd say  
16 is I think to hold our feet to the fire. It doesn't hurt  
17 us to say something about that kind of work in this kind of  
18 chapter and say, you know, this is what we're doing and  
19 these are the update recommendations that we provide. We  
20 are looking beyond this, and then say a few things about  
21 that. I don't think it would be a great risk, and since  
22 we're doing it anyway, I think it would be worth just

1 putting a placeholder in there.

2 DR. DeBUSK: Totally agree, just to say that  
3 we're interested in this idea, because we are crossing over  
4 into sort of a global payment, a risk-adjusted global  
5 payment tied to performance for primary care. That's a  
6 different day. I mean, I think that changes the way they  
7 behave.

8 DR. CROSSON: Karen.

9 DR. DeSALVO: I'm -- for this year I'll support  
10 the recommendations, though I do hope that we'll take up  
11 this work next year, and to that end, for next year, just  
12 two things. I don't remember if this is in the chapter so  
13 forgive me, but we really need to get a better handle on  
14 physician expenses in 2020 and beyond, because they've  
15 probably changed from what was thought before, including  
16 health IT and some differences in the kinds of team  
17 structure. What I know, anecdotally, is it's expensive to  
18 hire consultants to help you move to do MIPS and move to  
19 alternative payment models. So I'm not sure how much of an  
20 increase that really is after you have to do that work, as  
21 a practice.

22 But then related to the bonus thing is years ago,

1 when the patient-centered medical home movement was taking  
2 off, there was some talk about bonus not just for the  
3 clinician but for the team. And so as we're thinking about  
4 it and trying to drive team-based care and really encourage  
5 not just a lone doc taking care of patients but really  
6 thinking of them not only having partners but having teams,  
7 into next year maybe we can also think about structures  
8 that bonus an entire practice, not just support physician  
9 compensation to go up.

10 DR. CROSSON: Okay. Thank you.

11 DR. DeSALVO: I'll provide an aside on that.

12 Allan Goroll from Harvard wrote some stuff about that.

13 DR. PAUL GINSBURG: Yeah, and I want to follow up  
14 Karen's comments, and this came up when Ariel, before, was  
15 answering a question. The information we have on physician  
16 practice expenditures, you know, other than their income,  
17 the rest, compared to what we could know is a big gulf,  
18 because the last survey was 2007, you said, Ariel?

19 MR. WINTER: Based on data from '07 and 08.

20 DR. PAUL GINSBURG: Okay, 2007 and 2008. I  
21 remember how long CMS waited for that 2007 survey, how long  
22 it had been since the previous one. And I think we should

1 take it upon ourselves to encourage CMS. You know, and  
2 compared to the many billions of dollars that we spend to  
3 pay physicians, that we can't afford a survey more often  
4 than once every 10 of 15 years seems to be not a good way  
5 to manage policy.

6 DR. CASALINO: On this point.

7 DR. CROSSON: Yeah.

8 DR. CASALINO: Yeah, and I think that Karen is  
9 right. Dealing with what used to be called pay for  
10 performance and now value-based purchasing, and the EHRs  
11 and everything, this is all -- there was some of this in  
12 2007, but it's really accelerated. We're actually  
13 interviewing physician practices right now about the costs  
14 of dealing with MIPS, and there's no question that, I mean,  
15 new staff are being hired just to deal with these things,  
16 some to coordinate care but some to deal with just the data  
17 side of it.

18 So I think the expense picture might look  
19 different now than it looked in 2007, with almost all new  
20 categories. I think it's a good point, Paul.

21 DR. CROSSON: Our estimate is I remember it for  
22 the first year of MIPS for the physician community was \$1

1 billion in expenditure across the country.

2           Okay. Not seeing any future -- I mean, any more  
3 comments, so we have a recommendation before you. There it  
4 is. All Commissioners in favor of the recommendation  
5 please raise your hand.

6           [Show of hands.]

7           DR. CROSSON: All opposed?

8           [No response.]

9           DR. CROSSON: Abstentions?

10          [No response.]

11          DR. CROSSON: Seeing none, it passes unanimously.

12          Thank you, Rachel and Ariel. Brian, thank you  
13 very much.

14          Oh, I forgot. What happened to Dana? Yeah, so  
15 what do I do? Out loud?

16          Yeah, just an amendment. We had one Commissioner  
17 who was not present for the vote. So the vote was 16 to 0  
18 with 1 not present in voting.

19          DR. CROSSON: Okay. Now we're going to take up  
20 kind of double-ended discussion here. It's an update for  
21 outpatient dialysis facilities, as well as a policy  
22 recommendation, where we have a choice to make. Nancy and

1 Andy are here, and, Nancy, you have the floor.

2 MS. RAY: Thank you. Good afternoon. Today's  
3 presentation on assessing the payment adequacy of  
4 outpatient dialysis services consists of three seconds.  
5 First, I will answer some questions raised during the  
6 December meeting. Then I will summarize the indicators of  
7 payment adequacy that we reviewed in December. Lastly, I  
8 will present the draft update recommendation for your  
9 consideration.

10 The update analysis and recommendation will be  
11 included as a chapter in our March 2020 report. At the  
12 conclusion of our update discussion and vote, we will then  
13 turn to our discussion about refining the expanded ESRD  
14 transitional drug add-on payment, the TDAPA. The analysis  
15 about the TDAPA will be included in the June 2020 report.

16 As background, in 2018, there were roughly  
17 395,000 Medicare fee-for-service dialysis beneficiaries.  
18 They were treated at about 7,400 dialysis facilities, and  
19 total dialysis spending was \$12.7 billion in 2018.

20 So the revised chapter includes additional  
21 material about a number of issues raised at the December  
22 meeting. Dana, we have added more information about the



1 ESRD QIP. Several Commissions, including Kathy and Dana,  
2 we have added discussion about differences in outcomes  
3 between home and in-center dialysis patients and the  
4 retention of patients on home dialysis.

5 Warner, we have added additional information  
6 about the first two years of the ESRD ESCOs.

7 So now I will summarize the payment adequacy  
8 analysis. The indicators assessing adequacy are generally  
9 positive, and you have seen all of this material in  
10 December.

11 Regarding access, there is a net increase of  
12 about 350 facilities between 2017 and 2018. Our analysis  
13 suggests that there were few facility closures in 2017, and  
14 the few beneficiaries who were affected were able to obtain  
15 care elsewhere.

16 Regarding capacity, the growth in dialysis  
17 treatment stations has exceeded the growth in the number of  
18 fee-for-service dialysis beneficiaries between 2017 and  
19 2018. And looking at volume changes, the growth in the  
20 number of dialysis fee-for-service beneficiaries and  
21 Medicare-covered treatments remained steady.

22 The 18 percent marginal profit suggests that

1 providers have a financial incentive to continue to serve  
2 Medicare beneficiaries.

3           Moving to quality, the percent of dialysis  
4 beneficiaries using home dialysis has modestly increased  
5 from 10 percent to 12 percent, between 2013 and 2018.  
6 Hospital admissions has modestly declined, and mortality  
7 and percent of hospitalized beneficiaries with a  
8 readmission have held steady.

9           Regarding access to capital, indicators suggest  
10 it is robust. An increasing number of facilities are for  
11 profit and freestanding. Private capital appears to be  
12 available to the larger and small organizations.

13           Moving to our analysis of payments and costs. In  
14 2018, the Medicare margin is 2.1 percent. Between 2017 and  
15 2018, the TDAPA has increased the Medicare margin across  
16 rural and urban facilities and small and large providers by  
17 between two and three points.

18           Brian, the increase in the margin is due to an  
19 increase in payments per treatment between 2017 and 2018 by  
20 11 percent, while cost per treatment increased by 8  
21 percent. The 2020 projected Medicare margin is 2.4  
22 percent, a small increase from the 2018 margin.

1           So that leads us to the draft recommendation. It  
2 reads:

3           For calendar year 2021, the Congress should  
4 update the calendar year 2020 Medicare end-stage renal  
5 disease prospective payment system base rate by the amount  
6 determined in current law.

7           Regarding implications for beneficiaries and  
8 providers, we anticipate that beneficiaries will continue  
9 to have good access to care. Relative to current law, this  
10 recommendation will have no effect on reasonably efficient  
11 providers' willingness and ability to care for Medicare  
12 beneficiaries.

13           With that I turn it back to Jay.

14           DR. CROSSON: So without objection I think we're  
15 going to take these two separately. Seeing none, we will  
16 take this, as we decided in December, as an issue to vote  
17 on in our expedited voting process, which means that I will  
18 ask if there are any questions about anything that has  
19 changed between now and the December meeting relative to  
20 this update.

21           Seeing none, we will project the recommendation.

22           All Commissioners in favor of the draft recommend

1 please raise your hand.

2 [Show of hands.]

3 DR. CROSSON: All opposed?

4 [No response.]

5 DR. CROSSON: Abstentions?

6 [No response.]

7 DR. CROSSON: We are still missing one  
8 Commissioners. So we have 16 positive, 0 negative votes,  
9 and 1 Commissioner not present for the vote.

10 Okay. Andy? Who is up?

11 DR. JOHNSON: We are now going to discuss a new  
12 policy affecting payment to dialysis facilities for new  
13 ESRD-related drugs. In today's presentation we will review  
14 the transitional drug add-on payment adjustment, or TDAPA,  
15 discuss related issues, and present policy options for  
16 Commission consideration.

17 We are taking up this issue based on Commission  
18 interest during the December meeting. We plan to return to  
19 this topic in the spring and include it in a June report  
20 chapter.

21 One final note before I begin, in recent meetings  
22 Nancy has discussed the impact of TDAPA payments for

1 calcimimetics. Today's discussion will not address TDAPA  
2 policy for calcimimetics because the policy is a special  
3 case and the TDAPA period for calcimimetics is likely to  
4 end soon.

5           Today's discussion will focus on TDAPA policy for  
6 new ESRD-related drugs that are not yet available.

7           Prior to 2011, Medicare paid for dialysis  
8 services through a composite rate covering certain items  
9 and services, but many ESRD-related drugs were paid  
10 separately. The Medicare Improvements for Patients and  
11 Providers Act, or MIPPA, established the ESRD bundle of  
12 items and services and required all ESRD-related drugs to  
13 be included in the bundle, specifically citing drugs in the  
14 composite rate, erythropoietin-stimulating agents, or ESAs,  
15 and all other drugs and biologicals used to treat ESRD.  
16 The only exception for ESRD-related drugs is those that are  
17 oral only. Those drugs have been excluded from the bundle  
18 by law until 2025 or until a non-oral form is available.

19           Since 2011, Medicare has paid dialysis facilities  
20 a single rate per treatment that covers all items and  
21 services in the bundle, including equipment, supplies,  
22 labor, labs, and drugs using dialysis treatment.

1           In determining which drugs should be included in  
2 the bundle, the original bundle, in addition to the  
3 mandated composite rate drugs and ESAs, CMS reviewed  
4 dialysis claims and categorized all ESRD-related drugs into  
5 11 functional categories. The functional categories are  
6 listed in your mailing material. CMS identified the ESRD-  
7 related drugs by category to allow the agency to respond to  
8 changes in drug therapies over time by adding new drugs in  
9 one of the functional categories to the bundle upon market  
10 entry. CMS stated, "We did not finalize a specific list of  
11 drugs and biologicals because we did not want to  
12 inadvertently exclude drugs that may be substitutes for  
13 drugs identified, and we want the ability to reflect new  
14 drugs and biologicals as they become available."

15           With a policy based on functional categories in  
16 place, one issue remained: How would the ESRD prospective  
17 payment system address new ESRD-related drugs? This  
18 depends on whether the new drug is in one of the functional  
19 categories or not.

20           Two policies have been developed to address new  
21 ESRD-related drugs. We will start by talking about the  
22 policy for new drugs that are not in an existing functional

1 category, shown in the center column. These drugs are, by  
2 definition, outside of the current ESRD bundle, and the  
3 cost of providing these drugs is not included in the base  
4 payment rate.

5           The Protecting Access to Medicare Act, or PAMA,  
6 directed the Secretary to establish a drug designation  
7 process that would determine how to include new injectable  
8 and intravenous products in the bundle.

9           In response to PAMA, the Secretary established  
10 the first transitional drug add-on payment adjustment  
11 policy. For 2016, new drugs that are ESRD-related but not  
12 in an existing functional category would receive a TDAPA  
13 equal to the average sales price for at least two years.

14           After that, the new drug would be included in the  
15 bundle by modifying an existing functional category or  
16 adding a new one. In addition, the ESRD base rate would be  
17 updated to account for the expansion to the bundle, using  
18 the data collected during the two-year TDAPA period.

19           A second TDAPA policy was added later addressing  
20 new drugs that are in an existing functional category,  
21 shown in the right column. This policy will be the focus  
22 of the remainder of this session.

1           As a reminder, drugs in a functional category are  
2 included in the bundle, and payment for these drugs is  
3 covered under the base rate.

4           When establishing the bundle in 2011, and in  
5 response to PAMA in 2016, CMS stated that no TDAPA would be  
6 paid for new drugs in an existing functional category.  
7 Such drugs would be included directly into the bundle with  
8 no update to the base rate.

9           However, through two subsequent rounds of  
10 rulemaking, CMS expanded the TDAPA policy to include some  
11 of these drugs.

12           Starting in 2020, new drugs in a functional  
13 category that use certain FDA approval pathways are  
14 eligible for a TDAPA. Eligible drugs include those with  
15 new molecular entities, new active ingredients, and  
16 biosimilars, among others.

17           CMS determined that biosimilars are eligible for  
18 a TDAPA because the technology used to develop biosimilars  
19 is sufficiently innovative.

20           Examples of drugs excluded include those that are  
21 considered "new" due to a change in pill size or inactive  
22 ingredient, those that were previously marketed or



1 available over-the-counter, and also generics.

2           For new drugs in an existing functional category,  
3 facilities will receive a TDAPA equal to the average sales  
4 price for two years in addition to the full base rate.  
5 After that, the drug will be included in the bundle with no  
6 change to the base rate.

7           There are two main issues with paying a TDAPA for  
8 drugs in an existing functional category.

9           First, paying separately for new ESRD-related  
10 drugs is a form of unbundling the ESRD bundle. It reduces  
11 the competition that would occur if all drugs with the same  
12 function were paid under a single rate, and it fails to  
13 provide an incentive for manufacturers to lower launch  
14 prices.

15           An example showing the value of maintaining the  
16 bundle occurred in 2015 when an ESA substitute entered the  
17 market. Within one year, one-quarter of patients had  
18 switched to the new, lower-cost drug and the total ESA  
19 costs had declined.

20           A second issue is that the TDAPA payment is  
21 duplicative of the payment for drugs already included in  
22 the bundle. A patient needing a drug for a certain

1 function will either take a drug already included in the  
2 bundle, and the facility will receive the base payment  
3 rate, or the patient will take the drug receiving a TDAPA,  
4 and the facility will receive the full base rate plus the  
5 TDAPA.

6           Not only is the TDAPA duplicative, it creates a  
7 financial incentive to provide TDAPA-covered drugs over  
8 drugs in the bundle and potentially promotes the overuse of  
9 TDAPA-covered drugs.

10           There are also issues with the eligibility  
11 criteria to receive a TDAPA. Most importantly, the TDAPA  
12 policy does not apply substantial clinical improvement  
13 criteria and, therefore, will increase payment for drugs  
14 that offer no clinical improvement over available drugs.

15           The policy fails to protect the well-being of  
16 beneficiaries and fails to ensure good value for Medicare  
17 and taxpayer spending.

18           CMS does apply a significant clinical improvement  
19 standard in other cases, such as to new technologies under  
20 the inpatient and outpatient payment systems, and to new  
21 equipment and supplies under the ESRD payment system.

22           Finally, paying a TDAPA for biosimilars negates

1 their primary value by removing them from the bundle for  
2 two years. Biosimilars are not clinically superior to  
3 their originator biologic, and they would not meet a  
4 significant clinical improvement criteria. However,  
5 biosimilars can foster lower drug prices through  
6 competition when included in a bundle.

7           We are presenting two policy options that would  
8 replace the current TDAPA policy for new drugs in an  
9 existing functional category. Commissioners can choose one  
10 of these options. The first option is to eliminate the  
11 TDAPA for new drugs in a functional category. When these  
12 drugs enter the market, they would immediately be included  
13 in the ESRD bundle with no changes the base rate.

14           A second option is to limit TDAPA eligibility by  
15 applying significant clinical improvement criteria to new  
16 ESRD-related drugs. This option would also propose to  
17 avoid duplicate Medicare payments by reducing the TDAPA  
18 payment by the amount paid through the base rate for drugs  
19 in the same functional category.

20           Under either option, the TDAPA policy for drugs  
21 that are not in an existing functional category would  
22 remain in place.

1           The set of items and services covered by the ESRD  
2 bundle has been fairly stable over time. In recent years,  
3 a few new drugs have been incorporated directly into the  
4 bundle.

5           However, the TDAPA is intended to provide an  
6 incentive to create new ESRD-related drugs, and CMS  
7 recently introduced a similar ESRD transitional add-on  
8 payment adjustment for new and innovative equipment and  
9 supplies.

10          The add-on payment for equipment and supplies  
11 requires that the new items meet significant clinical  
12 improvement criteria.

13          Some stakeholders are concerned that over time  
14 the base rate may become insufficient to support new drugs,  
15 equipment, and supplies, particularly if the new items meet  
16 a clinical improvement standard.

17          As you know, the Commission monitors dialysis  
18 costs and payment adequacy and makes recommendations to  
19 Congress every year. If, in some future year, Nancy  
20 reports that payments to dialysis facilities have become  
21 inadequate, the Commission could consider a recommendation  
22 to address the underlying issue.

1           If warranted, one option the Commission could  
2 consider is rebasing the ESRD PPS. Rebasing is the process  
3 of calculating a new base rate using the current set of  
4 bundled services, incorporating their utilization patterns  
5 and prices.

6           Currently, rebasing the ESRD PPS requires  
7 congressional authority. In 2014, Congress required the  
8 Secretary to rebase the ESRD PPS due to changes in drug  
9 utilization. In this case, rebasing with lower overall  
10 costs led to a significant reduction in the base payment  
11 rate.

12           However, if new technology increases overall  
13 costs, rebasing the payment system could drive up Medicare  
14 payment rates. That is the reason we are now discussing  
15 rebasing only after an issue is identified.

16           To review, the current policy does not apply a  
17 clinical improvement standard and duplicates Medicare  
18 payment for drugs already included in the bundle. The  
19 policy options addressing new ESRD-related drugs in a  
20 functional category are, one, to eliminate the TDAPA or,  
21 two, limit TDAPA eligibility using significant clinical  
22 improvement criteria.

1           Neither option addresses the TDAPA policy for new  
2 drugs outside of the bundle. As always, we will continue  
3 to monitor changes in dialysis cost and payment adequacy  
4 each year and report any issues to the Commission.

5           For today's discussion, we seek input on these  
6 policy options, and depending on the feedback, we can work  
7 toward a recommendation this spring.

8           Thanks, and I'll turn it back to Jay.

9           DR. CROSSON: Thank you very much, Andy.

10          We're now open to clarifying questions. Kathy.

11          MS. BUTO: Do we have any data -- I should ask  
12 this question first. I was trying to figure it out. Has  
13 the policy where new drugs that fall within an existing  
14 functional category, do we have any experience with that  
15 policy and whether or not there's been a wholesale shift to  
16 the new drug since the base payment rate is not going to be  
17 reduced? Any experience with that or is it too new a  
18 policy?

19          MS. RAY: So under the TDAPA, the only drugs that  
20 have gotten the TDAPA to date are the two calcimimetics.

21          MS. BUTO: Oh, okay. So no drugs that fall into  
22 an existing functional category.

1 MS. RAY: That's correct.

2 DR. JOHNSON: Since the bundle was implemented,  
3 there have been new drugs that fell into a functional  
4 category, and without --

5 MS. BUTO: They have just been folded in?

6 DR. JOHNSON: Yeah, prior to any TDAPA policy,  
7 they were folded in.

8 MS. BUTO: Thank you.

9 DR. CROSSON: Brian.

10 DR. DeBUSK: It's sort of unfair because it's a  
11 clinical question, but could you give us a feel for are  
12 there barriers, I mean, are there certain categories, drug  
13 categories now in the ESRD bundle that, say, need a  
14 breakthrough or that -- I mean, are we -- I know it's an  
15 unfair question. Neither of you are doctors. But are  
16 these adequate drugs? Or are there drugs there that are  
17 still woefully -- say lots of side effects or difficult to  
18 administer?

19 DR. CROSSON: Just a suggestion, but you've got  
20 one right next to you.

21 DR. DeBUSK: Oh, I've already pinged him.

22 [Laughter.]

1 DR. DeBUSK: He dodged the question or else I  
2 would ask him.

3 DR. CROSSON: I saw he wasn't jumping up and  
4 down.

5 DR. DeBUSK: I would think you'd know a lot about  
6 the clinical aspects of this, so I'm sure he's going to  
7 weigh in. But he'd be the perfect person, yes.

8 DR. CROSSON: Yeah, I mean, I'm not the one to  
9 ask. Is there anybody here who might want to --

10 [Laughter.]

11 DR. JAFFERY: Yeah, I mean, I think that's a  
12 difficult question to answer. Are there opportunities for  
13 breakthrough in any of these functional categories? I  
14 don't know. You know, maybe some of the -- maybe phosphate  
15 binders. I don't know. There's nothing that jumps out  
16 that says this is more or less an opportunity.

17 MS. RAY: So the only thing that I can mention --  
18 and, again, as we've been informed from stakeholders, there  
19 is a new drug in clinical trials that has an indication.  
20 I'm going to botch the pronunciation: pruritus, itching.

21 DR. CROSSON: Itching.

22 MS. RAY: Yes, yes. And I believe that drug has



1 an FDA breakthrough designation, at least according to the  
2 manufacturer's website.

3 MS. BUTO: Does it fall into an existing  
4 functional category, Nancy?

5 MS. RAY: It would, yes. In fact, it would  
6 probably fall into a functional category that's in the  
7 existing composite rate bundle.

8 DR. CROSSON: But it doesn't sound like,  
9 Jonathan, that this is a field that's rife for the  
10 introduction of new highly expensive pharmaceuticals, for  
11 example.

12 DR. JAFFERY: Yeah.

13 DR. CROSSON: Yeah, okay. Jon?

14 DR. PERLIN: Yeah, I think it's a great question,  
15 but it's a great question within a limited context, which  
16 is how we resolve this TDAPA. The work we do is not value-  
17 neutral. When I think of Medicare beneficiaries with end-  
18 stage renal disease, you know, I ask, where are the  
19 breakthroughs and care models that prevent the  
20 deterioration of established kidney disease? Where are the  
21 care models that prevent actually acute kidney injury that  
22 leads to chronic kidney disease? And where are the care

1 models that lead to definitive renal replacement,  
2 transplant and such? And so, you know, not this year, but  
3 as we go forward, I think those are some of the things that  
4 we're going to have to grapple with because, really, this  
5 is a very difficult disease. You know, I think this  
6 conversation speaks to the difficulty around it. But I  
7 think there's a bigger issue that has to do with the care  
8 of beneficiaries, the integrity or the continuity of care  
9 across many elements of the service.

10 DR. CROSSON: Which is one of the reasons we  
11 included hypertension management in the MA performance set.

12 Okay. Jonathan.

13 DR. JAFFERY: Yeah, just to build on what Jon  
14 said, I certainly agree with that, and to me that's one of  
15 the trickiest things with grappling with ESRD payment  
16 policies that we're doing -- we're talking about something  
17 that's predominantly a Medicare payment -- Medicare  
18 payments, where a lot of the real opportunity is a little  
19 bit upstream, or more than a little bit upstream, where  
20 it's a mix of payers, and Medicare is only one of a number  
21 of payers. And even if you think about something like a  
22 drug to treat pruritus, which would be a symptom that might

1 drive somebody who's on the border of starting dialysis to,  
2 in fact, initiate dialysis, that might have more utility --  
3 or I shouldn't say that necessarily, but that might have  
4 some significant utility that would be helpful in that pre-  
5 ESRD space, but that's very different from what we're  
6 talking about here, which is this unique -- we've got these  
7 bundles, and now we are, like you said, thinking about  
8 potentially unbundling some of it.

9 DR. CROSSON: Pat.

10 MS. WANG: You know, just to underscore the  
11 point, I thought it was -- the statistics in the report on  
12 who suffers from ESRD in the Medicare program were really  
13 striking, about your point, 70 percent LIS, a  
14 disproportionate number under the age of 65. So really  
15 what you're talking about is the importance of Medicaid and  
16 other coverage for folks -- you know, they don't even get  
17 to 65, disproportionately African American, health  
18 disparities, socioeconomic -- I mean, it just underscores  
19 that by the time Medicare gets folks, it's a little late.

20 I wanted to ask a question about the SCI process.  
21 How would that work? Is this something that would be  
22 burdensome on CMS? Would it add value to really ask CMS to

1 be making judgment calls about what's substantial clinical  
2 improvement? Is the lemon worth the squeeze given that  
3 there aren't a ton of new drugs coming down the pipeline?

4 MS. RAY: Sure. So CMS already implements a  
5 substantial clinical improvement criteria in the inpatient  
6 setting for the new technology add-on payment, and that's  
7 done for new drugs and new devices. And there they look at  
8 whether or not the new technology substantially improves  
9 the diagnosis or treatment of the patient. So there is a  
10 process in place. There's also a similar substantial  
11 clinical improvement criteria for outpatient devices as  
12 well.

13 MS. BUTO: Nancy, I don't think very many drugs -  
14 - maybe one drug has passed that test in the inpatient  
15 side. I'm looking for Jeff or somebody in inpatient. It's  
16 rarely -- how many? Eight, okay. In the last like 15  
17 years since it was enacted, I think.

18 [Comments off microphone.]

19 MS. BUTO: Oh, just in the year 2020. Okay.

20 DR. CROSSON: So it would be reasonable to say I  
21 think what we're saying here is if the Commission were to  
22 gravitate towards Option 2, we would assume, all things

1 notwithstanding, that this would be something that CMS  
2 could theoretically do, because there are not going to be  
3 hundreds of these drugs coming forward in any given year.

4 MS. RAY: One would think so, yes.

5 DR. CROSSON: Okay. Seeing no further questions,  
6 we'll move to the discussion. You have the discussion  
7 slide up there, which I think presents the options, and  
8 Kathy's going to lead off.

9 MS. BUTO: Okay. My take on this is that there  
10 isn't a strong justification to TDAPA for drugs that  
11 already have a functional category. In other words, status  
12 quo, they should be able to be paid as part of the base.

13 I'm also looking at the 18 percent marginal  
14 profit that facilities are enjoying, and I'm aware of the  
15 fact that probably the bigger issue, in a way, to me, is  
16 the fact that biosimilars will not get special treatment.  
17 One could argue that if they got special treatment,  
18 facilities would use them more often. Yes, but it would  
19 cost the program twice as much or one and a half times as  
20 much, because there's money in the base, and then you'd be  
21 paying for the biosimilar.

22 I think that issue is also an issue in the

1 outpatient department. In other words, I think biosimilars  
2 are eligible for separate payment in the outpatient  
3 department, even though there's a drug already being paid  
4 for under OPPS, so, I guess, again, setting up in that case  
5 not so much something is in the base versus something  
6 outside, but an issue of a level playing field.

7           Andy?

8           DR. JOHNSON: Yeah. And I think this is what you  
9 meant, but just to clarify that biosimilars are eligible  
10 for a TDAPA. But the generics are not eligible for TDAPA.

11           MS. BUTO: Right. Right, right.

12           So, I mean, my point is that's another reason why  
13 I would not allow TDAPA for drugs that fall within an  
14 existing functional category because then -- I think you  
15 pointed out in your example the biosimilar that was  
16 available then was able to lower the cost of treatment  
17 because it was considered as part of the bundle. That's my  
18 sense.

19           The issue of substantial clinical improvement  
20 might be another way to go, but I would reserve that for  
21 actually drugs that are seemingly new, because even though  
22 they don't have a functional category -- and I know we're

1 not talking about them here -- there may be drugs that, in  
2 a sense, are a substitute for something in a functional  
3 category. I don't think we know yet. So it's something to  
4 think about as you get to that issue is whether substantial  
5 clinical improvement ought to be a criteria for drugs that  
6 are outside a functional category.

7           Again, I just go back to the fact that the  
8 margins are pretty healthy, and there aren't very many  
9 drugs involved probably in the pipeline that have to be  
10 considered here, so it seems to me a place where we should  
11 be, anyway, as a Commission.

12           DR. CASALINO: Kathy, you're arguing for Option  
13 1?

14           MS. BUTO: Yeah, Option 1.

15           DR. CROSSON: Jonathan?

16           DR. JAFFERY: Yeah. Thanks. Thanks for bringing  
17 this work today, and I would tend to agree with Kathy.

18           And I think the bundle -- we've seen a few things  
19 in this bundle that have been successful. You give the  
20 example of the newer ESA, but even the initial one we saw,  
21 pretty dramatic changes in utilization of IV iron versus  
22 ESAs, which actually had probably pretty important clinical

1 benefit too, now with some of the stuff we know about  
2 cardiovascular risk and ESAs. That was a pretty rapid  
3 switch in practice that I think we attributed to probably  
4 both those things.

5 I guess one thing that maybe -- I want to make  
6 sure I understand this correctly, and this may -- if I do,  
7 then maybe it's a slightly different suggestion than 1 or  
8 2.

9 While I would go with what Kathy was saying about  
10 eliminating the TDAPA here, where it says new drugs would  
11 be included with no update to the base rate, I wonder if it  
12 would be possible to not have a TDAPA but still allow an  
13 update or even encourage it.

14 And an update could potentially go in both  
15 directions. So if it showed clinically -- clinical  
16 superiority, maybe we wouldn't increase it if its cost was  
17 higher. If we saw something like a biosimilar or a number  
18 of biosimilars come in, maybe there would be an update that  
19 would decrease it, somewhere between the reference biologic  
20 and biosimilar.

21 So it's maybe a modified recommendation around  
22 eliminate it but allow or even encourage updates at the



1 time, every so often or at the time of enter into the  
2 market.

3 MS. BUTO: Jonathan, I think that was the  
4 rebasing approach that Andy and Nancy were talking about,  
5 which is every X amount of time, you go back to look to see  
6 where costs had gone up or gone down.

7 DR. CROSSON: I think he's talking about  
8 something different.

9 MS. BUTO: Are you talking about another  
10 passthrough?

11 DR. CROSSON: Drug-specific --

12 MS. BUTO: Just specific to drugs?

13 DR. JAFFERY: Correct, yeah.

14 MS. BUTO: So that sounds more like Option 2, I  
15 think.

16 DR. JAFFERY: But my understanding with Option 2  
17 is there would be a separate payment for that specific  
18 drug, that new drug that comes, and you'd have, let's say,  
19 a two-year period where you get the bundled rate, and then  
20 you'd get a separate payment specifically if you use that  
21 drug, which would drive the market towards using that new  
22 drug. And you'd get both.

1           What I was suggesting is that you would say, "No.  
2 This new drug comes in. We'll include it in the bundle,"  
3 but at that point, we would reassess and see is that bundle  
4 adequate. And we might say -- CMS might say, "Well, it's  
5 really just a me-too drug or a biosimilar, and so we are  
6 going to leave the bundle alone, or we might even decrease  
7 it." Or they'll say, "We're going to include it, and it's  
8 actually got clinical superiority. And so we do think that  
9 there's some value in encouraging the use of that drug."

10           MS. BUTO: If I could just make a comment on  
11 that. The only example that comes to mind of something  
12 like that is when TPA was approved. There was a movement  
13 to get TPA added to the inpatient PPS system as sort of a  
14 passthrough, and at the time, Glenn Hackbarth was the  
15 Deputy Administrator. We resisted doing that, and it  
16 turned out, even though it was a very expensive drug, that  
17 overall costs related to conditions treated by TPA, heart  
18 attack, et cetera, went down.

19           So because it was an effective drug, it had the  
20 effect of reducing costs in other ways to the whole bundle.  
21 So the issue with making adjustments for something in a  
22 bundle, but if you're just doing a piece of it is, is the

1 rest of the bundle might change too. So it's just  
2 something to think about.

3 DR. JAFFERY: So now are you arguing for TDAPA?

4 [Laughter.]

5 MS. BUTO: I'm arguing not to make any changes,  
6 except to rebase periodically, to capture all those changes  
7 and costs, because there are going to be changes in  
8 supplies, changes in drugs, and maybe some different ways  
9 to achieve adequacy of dialysis.

10 DR. CROSSON: Okay. Paul, you just wrote  
11 yourself down.

12 DR. PAUL GINSBURG: Yeah.

13 I suppose Kathy's perspectives on this issue, and  
14 I wanted to bring up one more issue that makes me  
15 particularly cautious about changing policy.

16 There's a situation that I think is somewhat  
17 unique to ESRD where Medicare, of course, is such a large  
18 part of the market in ESRD. So there's an opportunity for  
19 a new drug that is specific to ESRD to come in and have a  
20 virtually unrestrained average sales price, which then gets  
21 brought into the ESRD system. And just the chance of that  
22 happening is reason to be very cautious in any of these

1 policies, which would automatically have a passthrough and  
2 then actually drive up the price of the bundle.

3           So that's why I agree with Kathy in supporting  
4 No. 1.

5           DR. CROSSON: Pat. Pat and then Brian.

6           MS. WANG: I see a lot of appeal to Option 1 and  
7 the comments that Kathy and Paul have just made, and  
8 perhaps I should have asked this in Round 1. The slight  
9 hesitation that I have is for the very fact, Paul, that you  
10 just mentioned, that Medicare is sort of like the biggest  
11 purchaser. Will it discourage manufacturers from doing  
12 more R&D for drugs to be part of the ESRD treatment?

13           I don't really understand what the rationale was  
14 behind adding all of these duplicative payments, other than  
15 perhaps a fear that there wasn't enough new launches in  
16 this area, and it was meant to be like an extra big bonus  
17 to incentivize manufacturers to participate and develop  
18 stuff here. So that would be my only concern, and I guess  
19 that I would just -- and that would sort of suggest that  
20 maybe Option 2, even though it's a little bit squishier,  
21 would hedge that danger.

22           MR. RAY: So just to give some information, when

1 CMS expanded the TDAPA and the two rulemaking processes,  
2 they did argue that they were doing so to encourage  
3 innovation in this area for both drugs in 2018 for the 2019  
4 final rule and for equipment and supplies for the 2020  
5 payment rule.

6 DR. CROSSON: Brian?

7 DR. DeBUSK: I was actually going to echo Pat's  
8 comment too. I want to believe in 1, and you want to lean  
9 toward 1. So, Kathy, I'm with you.

10 The concern, though, is Medicare is such a big  
11 part of this. I mean, Medicare could single handedly stop  
12 a would-be innovation in one of these 11 categories.

13 My thought, again, I'm still learning toward 1,  
14 and I don't even know if this is a reasonable ask of you  
15 guys. But are there people who have looked at those 11  
16 categories and looked at what are the needs by category? I  
17 mean, is there the hope of a drug that improves quality of  
18 life or that reduces mortality? Is there a glaring need  
19 there that maybe we could inadvertently stifle? Because,  
20 again, if we do shut that down, it's not like the  
21 commercial payers are going to pick it up and fix it or the  
22 MA plans are going to fix it. I mean, MA is the lead.

1           And, again, maybe it's an unfair question, but  
2 just something to give us a color for how mature the drugs  
3 in this segment, when's the last drug -- when maybe was the  
4 last update in any of these categories? If these  
5 categories haven't been changing in the last 20 years,  
6 they're probably not going to change in the next two. But  
7 if this is a vibrant sector, I just wish we could capture  
8 that somehow.

9           DR. CROSSON: On that, well, Paul had first come  
10 in and then Bruce.

11           MR. PYENSON: If you look at the 11 categories,  
12 at least the most expensive ones are also used to treat CKD  
13 stages 1 through 4 and 5 pre-dialysis. So it's not as  
14 though -- and those populations are vastly bigger than end-  
15 stage renal disease.

16           I'd also point out that commercial payers are not  
17 insignificant. You can get a sense of that. The Medicare  
18 margins are quite a bit lower than the total margin.  
19 They're all positive, but there's lots of money flowing  
20 from not only commercial payers but also for Medicare  
21 Advantage currently, even before the rule changes for 2021,  
22 allowing dialysis patients to enroll.

1           So I think it's not as, perhaps, monopolistic  
2 from a Medicare restraining the market as it could be.

3           DR. CROSSON: And you're saying there's still  
4 enough money there to stimulate innovation?

5           MR. PYENSON: There seems to be no shortage of  
6 money.

7           DR. CROSSON: No shortage of money.

8           DR. PAUL GINSBURG: This is when I was going to  
9 comment and remind people that the United States is not the  
10 only high-income country in the world that treats ESRD. So  
11 there's still an important market abroad, although there is  
12 a potential to set a price in the United States, many  
13 multiples of the price that's set elsewhere.

14          DR. CROSSON: Kathy?

15          MS. BUTO: Yeah. I was going to mention that the  
16 first erythropoietin drug was approved as an orphan drug  
17 for ESRD, but its greater use was for cancer and other  
18 things. And, of course, I guess sports doping and other  
19 things. So the point is -- and I'll go back to what Bruce  
20 said. I think the manufacturers now think that the chronic  
21 kidney disease population, which is growing, is the big  
22 market. It's pre-dialysis, but some of the same drugs are

1 needed.

2           And, Jonathan, you would have much more insight  
3 to that.

4           DR. JAFFERY: Yeah. The ESAs are exactly in that  
5 category. Clearly, injectables are not things that are  
6 easy to give, but sub cu or oral medications clearly are  
7 used a lot in pre-ESRD, CKD mostly 3, 4.

8           DR. CROSSON: So we seem to be not of one mind  
9 here. I just want to test something. So Jonathan's  
10 suggestion was basically Option 1, but that we -- if I get  
11 this right, that CMS would then have the ability  
12 automatically, would have the ability to rebase the bundle  
13 based on the introduction of a drug that either  
14 demonstrably -- and this is unrelated to clinical  
15 effectiveness, but demonstrably changed the cost profile  
16 for managing the bundle. That was your proposal, I think,  
17 right?

18           DR. JAFFERY: Yeah. I mean, I think there was a  
19 part about demonstrably changing clinical outcome, but that  
20 would be, I think, folded into the -- that would be that  
21 CMS could increase it if they felt that was the way.

22           DR. CROSSON: One of the criteria that CMS could



1 use to reprice the bundle.

2 DR. JAFFERY: Yeah.

3 DR. CROSSON: So would that be enough to resolve  
4 the issue about -- if we went purely with No. 1, would that  
5 be enough to resolve the issue about creating an economic  
6 barrier to innovative drugs? It seems to me, it might.

7 DR. JAFFERY: That's what I was trying to get at.  
8 I think I'd leave it to others to decide if they feel it  
9 would.

10 DR. CASALINO: CMS periodically rebases on some  
11 quasi-regular schedule or --

12 DR. JOHNSON: Not right now, no.

13 DR. CASALINO: How hard would it be to get CMS to  
14 rebase? I guess, is one question, and the corollary  
15 question is -- Kathy was pointing out, and I think this  
16 really needs to be emphasized. The drug could still be a  
17 lot more expensive like TPI, but if it saves dramatically  
18 another cost, which it could, putting it into the bundle  
19 could actually make the bundle cheaper and not more  
20 expensive.

21 So this rebasing would not be a trivial process.  
22 It would be doable, but it would require some calculations.

1 But is it a realistic expectation? If you're a  
2 manufacturer, are you thinking, "Okay. Yeah. We'll get  
3 thing rebased, and we'll get well compensated," or it's  
4 just a very hard thing to get to happen.

5 DR. CROSSON: All right. What we've got here is  
6 we have a situation right now that we think is not the  
7 right policy. So we want to pick something that we think  
8 is a better policy.

9 The pure Option No. 1 creates this concern, and  
10 maybe the concern isn't as great as some have made it out  
11 to be.

12 The other two options create a requirement for  
13 CMS to do some level of analysis to determine whether or  
14 not to allow the TDAPA based on its clinical efficacy,  
15 which would require one level of analysis, or the other one  
16 would be to do the -- do something essentially similar but  
17 based on a more comprehensive analysis of the impact of the  
18 introduction of the new drug on the cost of the bundle,  
19 which could be just the impact of the drug itself or could  
20 be the impact of the drug itself combined with other  
21 clinical changes in terms of the total cost of care for  
22 that bundle, which could, of course, take more than a

1 trivial amount of time to ascertain, it would seem to me.

2 MS. BUTO: I was going to say you couldn't figure  
3 that out at the moment of introduction.

4 DR. CROSSON: No, you couldn't. You couldn't.

5 MS. BUTO: And so that would have to be a  
6 rebasing issue, it seems to me.

7 The other thing is the manufacturer is going to  
8 have every incentive if you potentially would allow greater  
9 cost for that launch price to be high.

10 DR. CROSSON: It would be higher.

11 MS. BUTO: I'm reacting based on what I know --

12 DR. CROSSON: Coming back to where you were in  
13 the beginning.

14 MS. BUTO: -- the behavior has been in the past.

15 DR. JAFFERY: Can I ask a question?

16 DR. CROSSON: Go ahead, and then Larry.

17 DR. JAFFERY: So if there is no TDAPA, if we go  
18 with Option 1, and let's say we had a drug introduced  
19 that's like the example of TPA -- so the way you described  
20 TPA was it was a passthrough or it wasn't going to be, but  
21 so if we had a --

22 MS. BUTO: It wasn't a passthrough.

1 DR. JAFFERY: It wasn't a passthrough, but I  
2 guess what I was hearing from you was that maybe that was  
3 not the best approach overall because, actually, the use of  
4 the drug ended up lowering overall costs.

5 MS. BUTO: No. It was a great decision because  
6 if we had added the cost of TPA to the DRGs, it would have  
7 raised the cost, the relative weight of those DRGs, when,  
8 in fact, the DRG weight dropped. So it would have made  
9 exactly the wrong decision was my point.

10 DR. JAFFERY: So trying to balance that with  
11 driving the use of a new drug, I mean, I guess that's what  
12 we're trying to grapple with here.

13 MS. BUTO: The problem is this is a great area of  
14 uncertainty when something first comes in, and one thing  
15 that could happen is you could imagine maybe there's an  
16 exceptions process where there really is reason to think  
17 the complication rates are so much less or, you know,  
18 whatever it is, more patient will benefit from it, even  
19 though it's in a functional category. And you really want  
20 to use that or encourage use. Then maybe there's an  
21 exception to an SCI kind of thing.

22 But it's hard to rebase on the front end when you

1 don't know what the reduction in costs might end up being  
2 once the drug is -- if that happens or if all the other  
3 costs will go up.

4 DR. JAFFERY: Yeah. And I wasn't envisioning  
5 being able to rebase on that broader impact because I don't  
6 know that that's realistic. Again, on the cost, I guess  
7 would the exceptions process then allow for a separate  
8 payment, and how is that different? If not, then how is  
9 that different from updating the bundle?

10 DR. CROSSON: Larry.

11 DR. CASALINO: I'm just trying to understand.  
12 Would it be correct to say that Option 2 as written would  
13 not require rebasing, although when rebasing happens,  
14 rebasing would include whatever comes up with that drug.  
15 And Option 2, as Jonathan is proposing, is kind of  
16 "immediate rebasing." Is that a correct distinction?

17 DR. CROSSON: It's --

18 MS. BUTO: I think it's just an add-on, not  
19 rebasing. Rebasing usually means that some costs might  
20 come down.

21 DR. CASALINO: So --

22 DR. JAFFERY: I'm not suggesting an add-on.

1 MS. BUTO: Oh. I think that's what TDAPA is.

2 DR. JAFFERY: I understand. That's why I'm  
3 saying I was looking at a different -- I want to be clear.  
4 I'm not suggesting Option 2. I was suggesting -- I think  
5 Jay described a third pathway, which was that it was simply  
6 rebase which could cause the bundle to go up or down  
7 without a separate payment for the new drug.

8 MS. BUTO: Okay. So you might wait a year or so  
9 before you decide on the rebasing, or -- I'm just saying  
10 it's hard to do that on the front end. That was my only  
11 point, because you don't know what the costs are going to  
12 be.

13 DR. CROSSON: So that's because we've expanded on  
14 Jonathan's model. Initially, his model was just based on  
15 the cost of the drug, and then we've said, well, wait a  
16 minute, but there are other considerations in terms of the  
17 impact of the drug on the total cost of the bundle, which  
18 wouldn't come until later. So that's a fourth alternative,  
19 which is probably so cumbersome as to not be realistic.

20 DR. JAFFERY: But you could do an update on the  
21 front end just based on the cost of the drug potentially.

22 DR. CROSSON: Yes.

1 DR. JAFFERY: No, it's not Option 2.

2 [Comments off microphone.]

3 DR. JOHNSON: I'm not sure we'd know the cost of  
4 the drug if it's truly new coming right in. I think that's  
5 part of the issue with figuring out what to do with the  
6 update. And if there is money -- is the suggestion -- I'm  
7 just trying to understand -- then to provide some other  
8 amount, a separate payment but a different amount than the  
9 TDAPA --

10 DR. JAFFERY: Well, so not knowing the cost of  
11 the drug up front is a separate issue that I don't think we  
12 talked about or considered entirely. But, no, I'm not  
13 suggesting at all that we consider a separate payment.  
14 What I would not want to do is try and avoid, I think,  
15 what, Kathy, you've said in the first place with trying to  
16 not drive the incentive of you're already getting a hundred  
17 bucks, we're going to keep giving you a hundred bucks,  
18 you're getting a hundred bucks to use Drug A; now you're  
19 going to use Drug B, we will keep giving you the hundred  
20 bucks, and we'll give you whatever, another 50 bucks, for  
21 Drug B. Drug B comes out. It's included. We're not sure  
22 if it -- if Drug B is clinically superior to anything -- to

1 Drug A, and, in fact, is more expensive, we might then  
2 evaluate -- we could evaluate it and maybe increase the  
3 \$100 payment to \$125. If, in fact, Drug B is a biosimilar  
4 and it's actually 50 bucks, we might decrease the payment  
5 to \$75.

6 DR. JOHNSON: Correct me if I'm wrong, but that  
7 sounds like choosing Option 1 where there's no TDAPA, the  
8 new drug gets folded directly into the bundle, and then a  
9 year or a couple years down the road you figure out what  
10 has happened to the cost of the bundle? Has it increased  
11 because this new drug is expensive? Does this new drug  
12 offset other costs? And then consider rebasing if that's  
13 warranted. Is that --

14 DR. CROSSON: So Jonathan was saying do it right  
15 away. That's another version, which is more consonant with  
16 the issues that Kathy was describing. Now we have five  
17 options.

18 MS. BUTO: Andy, I think the difference between 2  
19 and what he's saying is you add the dollar amount to the  
20 bundle, regardless of whether they're using the new drug.  
21 Okay?

22 Number 2 requires you to use the new drug, right,



1 to get that additional payment?

2 DR. JOHNSON: Correct. It is a TDAPA payment  
3 when you use --

4 MS. BUTO: So the money goes in, but then the  
5 plan or the facility can make the decision to use a cheaper  
6 alternative, even though that additional money is in there.  
7 Is that --

8 DR. JAFFERY: Potentially. I guess I would also  
9 emphasize that -- we keep coming back to the example where  
10 the cost of the bundle goes up, and that's what I was  
11 trying to get at a place where we could take drugs that are  
12 coming in the market that are competitive and not  
13 necessarily clinical improvements and lower cost as well.

14 MS. BUTO: But don't you -- I mean, I'm not a  
15 pricing expert, but once the rule is known, and the rule is  
16 there will be an add-on, it's not tied to the use of your  
17 drug, why wouldn't the new manufacturer want to come in at  
18 the highest and some sort of parity pricing to what's in  
19 the bundle so that -- in other words, when would you ever  
20 get a lower cost with a new drug if that's the rule?  
21 Because there's no benefit to them necessarily to have the  
22 whole bundle go down, right? So why wouldn't they price

1 kind of at parity?

2 DR. CROSSON: Okay. Are you going to get us out  
3 of this, Bruce?

4 MR. PYENSON: Yes, get us out of this. For  
5 months at MedPAC we've been talking about the importance of  
6 accountability and risk, and I've been listening to this  
7 conversation about how to take risk away from a situation,  
8 which strikes me as very strange given, you know, the  
9 consensus that we had that accountability and risk is a  
10 good thing. So I think there are -- correct me if I'm  
11 wrong. There's already protections in place. There are  
12 some outliers and things of that sort that are there, and  
13 so I'm puzzled at the direction of the conversation given  
14 our previous enthusiasm for risk.

15 DR. CASALINO: What [off microphone]?

16 [Laughter.]

17 DR. CROSSON: Moving on to the next topic. I  
18 think -- yeah, so all right. Let me -- yeah, I think we've  
19 gone about as far as we -- I think -- I'm going to do  
20 something we don't normally do, which is a straw poll here,  
21 because I think we have to get some direction for the  
22 staff, assuming that what we want to have -- Jim, what you

1 want to have is something that we can vote on. So after  
 2 all this discussion, I'm going to ask for a show of hands -  
 3 - you're not committed to this, but for Option 1, Option 2,  
 4 or some variant of what Jonathan has proposed as a third  
 5 option.

6 DR. CASALINO: Could we just hear a statement  
 7 once more of what the third option is? Just a statement.

8 DR. JAFFERY: I'm not sure I can do this anymore.

9 [Laughter.]

10 DR. JAFFERY: And Kathy's last point was a fair  
 11 one that I would need to think through a little bit more.  
 12 But the idea was that there would not be any added  
 13 transitional payment, but at time of introduction of the  
 14 new drug, the bundle would be reevaluated and potentially  
 15 rebased.

16 DR. CROSSON: Okay. So that's Option 3. So all  
 17 those Commissioners who are predisposed to Option 1, please  
 18 raise your hand.

19 [A show of hands.]

20 DR. CROSSON: Number 2.

21 DR. JOHNSON: Can we pause on the comments, too?  
 22 Because I have some concern that Option 3, we wouldn't have

1 the data to update the bundle at the time that the new drug  
2 enters the market.

3 DR. CROSSON: Yeah, we've had this before. I  
4 can't quite understand. If the drug is entering the  
5 market, it has to enter at a price, right?

6 MS. RAY: Right, but, for example, CMS -- the  
7 rebasing of the bundle that happened in 2014, that used  
8 three years' worth, or maybe even more than that, of prior  
9 data, because you want to see how practice patterns change  
10 over time. You know, does one drug start substituting for  
11 another drug? Does one drug drop out? And so forth. And  
12 in this case, it was ESAs, and ESAs had to be titrated  
13 down. It wasn't an immediate drop.

14 DR. CROSSON: Yes. I get it, Nancy. I think  
15 Jonathan was basically -- or at least I was just thinking a  
16 drug costs ten bucks, you know, we add ten bucks or  
17 subtract ten bucks. And what you're talking about is  
18 utilization, utilization versus other things, all of that  
19 complexity. I understand that.

20 DR. JAFFERY: So if it's not feasible, clearly  
21 it's not a reasonable option, and I would go back to  
22 supporting Option 1 in the absence of that being feasible.

1 MS. MARJORIE GINSBURG: [off microphone] Option  
2 3?

3 DR. JAFFERY: No, and we can discuss this over  
4 dinner.

5 [Laughter.]

6 DR. CROSSON: Okay.

7 MS. BUTO: Jay, not to make this worse, but --

8 DR. CROSSON: But go ahead.

9 MS. BUTO: We could have Option 3 where it's  
10 always just the add-on for the drug into the bundle, if  
11 that's what -- we just have to recognize -- I wouldn't  
12 support that, but you'd have to recognize that it's never  
13 going to go down until you rebase. But if you want to  
14 leave the flexibility for a new drug, that would be the way  
15 to add to the bundle.

16 DR. JAFFERY: So we'll call that "Option Q"?

17 DR. CROSSON: It's rare for a Commissioner to  
18 pose an option and then say they oppose it, but --

19 [Laughter.]

20 MS. BUTO: Trying to be fair here.

21 DR. CASALINO: We should vote on how many people  
22 want to discuss this at dinner with Jon.

1 DR. CROSSON: Warner.

2 MR. THOMAS: Just a comment, I think, going to  
3 Larry's point about risk and trying to put risk to  
4 providers. And I think it's an area that, if I remember in  
5 the reading, it's got an all-in margin of 20 percent. It's  
6 got an extremely healthy Medicare margin. It's got  
7 tremendous consolidation amongst -- you know, two providers  
8 have nearly 80 percent or 75 percent of the market. I  
9 think probably putting more risk here and limiting some of  
10 these things probably makes a lot of sense. And, look, if  
11 it has a material impact, that may not be a bad thing. If  
12 it gets new entrants into the market, that's probably a  
13 good thing.

14 So we ought to put this conversation in the  
15 context of the total industry here and the 20 percent all-  
16 in margin of this area.

17 DR. CROSSON: Well said. David, you've been  
18 trying to get in.

19 DR. GRABOWSKI: Yeah, I was just going to say, I  
20 like Jonathan's idea if it's rebasing downstream, and I  
21 think we would do that anyway; even if things got out of  
22 whack, I think we would want to revisit kind of what we're

1 paying for each of these bundles. So I would hope, even if  
2 we're voting for 1, we're not going to just let this go on  
3 indefinitely, that at some point we'll go back and revisit.  
4 But I don't think we can do it instantaneously just given,  
5 as Nancy and Andy have been saying, there's offsets there  
6 and utilization and it's really hard to measure. But  
7 downstream I think we could definitely readjust the  
8 bundles, and I would hope we would.

9 DR. CROSSON: Okay. Pat.

10 MS. WANG: I just want to say I don't think that  
11 the issue of risk is on the provider. It's the risk that  
12 manufacturers won't see enough in it for them. I think  
13 that this TDAPA is designed to incentivize manufacturers to  
14 get in because they know they're going to get paid a lot of  
15 money. And so I think Option 1 is the right way. The only  
16 thing I would say is maybe there should be an exceptions  
17 process as long as it's not something you can drive a truck  
18 through, because let's say that there is another TPA that  
19 comes along and it's really expensive, at least in the  
20 beginning. You would want that to be -- you would want a  
21 manufacturer to feel like that's going to be recognized  
22 sooner than the next updating of the bundle. I think

1 updating on the front end, for all the reasons people have  
2 said, it's a really neat idea. I think it's really  
3 complicated, and what happens if you have two or three new  
4 drugs? Are you going to be juggling all this stuff to  
5 figure out what the proper update is?

6           So that's my perspective on risk.

7           DR. CROSSON: So I think what I'm hearing from  
8 you is support for Option 1 with perhaps in the text some  
9 discussion about a rare but available exception process on  
10 the part of CMS, different from what they're doing now, and  
11 then suggestion for periodic rebasing, if there's going to  
12 be a lot of turnover in drug use in the industry.

13           Okay. So let's try this again. Commissioners  
14 who are predisposed to Option 1, raise your hand.

15           [A show of hands.]

16           DR. CROSSON: Option 2? Option 2, one.

17           Option 3?

18           [No response.]

19           DR. CROSSON: Okay. So I think that should  
20 provide some direction. Okay. Thank you very much. An  
21 important issue, and thank you for bringing it to us so  
22 clearly so we could make some judgments.



1 [Pause.]

2 DR. CROSSON: Okay. Now we're going to move on  
3 to a portion of the agenda where we have reached consensus,  
4 we believe, on updates, and so we're going to go through an  
5 expedited presentation and voting process, and we're going  
6 to start with a bundle of post-acute care, and, Carol,  
7 you're going to introduce that for us?

8 DR. CARTER: I am going to lead off.

9 In response to Commissioner comments at the  
10 December meeting regarding the broader direction of post-  
11 acute care, we've included a short introduction to the PAC  
12 update chapters, and that was all mailed to you. The  
13 chapter makes three points.

14 First, payment levels in the three settings are  
15 high relative to the cost of care and need to be lowered.

16 Second, it commends CMS on the revised PPSs for  
17 home health care agencies and skilled nursing facilities  
18 that will increase the equity of Medicare's payments, but  
19 we note that the provider responses may warrant revisions  
20 in the future. The changes encouraged by the revised PPSs  
21 are consistent with an eventual unified payment system  
22 across all post-acute care.

1           Finally, we note that the reporting of the  
2 functional assessment data may be biased in ways that raise  
3 payments. Our work raised serious questions about tying  
4 payments to these data and underscored the importance of  
5 improving the consistency and accuracy of this information.

6           And now we'll turn to the setting-specific update  
7 recommendations. These presentations will be abbreviated,  
8 but the material in the chapters was fully discussed at the  
9 December meeting.

10           All right. We'll begin the update discussions  
11 with skilled nursing facilities. This chapter includes  
12 information that was requested at the December meeting.

13           Jonathan, you asked to see information about the  
14 variation in occupancy rates, and I included that.

15           Amol, you asked about where small SNFs were  
16 located, and we included that information.

17           I also added new information on the second-year  
18 performance under the VBP because that was released just  
19 after the last meeting.

20           Here's a reminder of the SNF industry in 2018.  
21 There were about 15,000 providers, most of which also  
22 provide long-term-care services. About 1.5 million

1 beneficiaries or about 4 percent of fee-for-service  
2 beneficiaries used SNF services, and program spending,  
3 \$28.5 billion.

4 Medicare makes up a small share of most nursing  
5 facilities' volume and revenue, about 10 percent of days  
6 and about 18 percent of revenues. Both of these have  
7 declined in recent years, in large part because of the  
8 expanded enrollment of beneficiaries into Medicare  
9 Advantage plans.

10 The indicators on the adequacy of payments are  
11 all positive. Beneficiaries appear to have access to  
12 services. Supply was stable, and the volume declines  
13 paralleled the changes in inpatient hospital care, which is  
14 a requirement for coverage. The marginal profit was high.

15 With regards to quality of care, the risk-  
16 adjusted rates of discharge to community and the two  
17 readmission measures are moving in the desired directions.  
18 All three improved between 2017 and 2018.

19 SNFs have adequate access to capital, and this is  
20 expected to continue in the coming year. The total margin  
21 reflects how -- the low payments made from other payers.  
22 Medicare margins in 2018 were high and are expected to

1 remain so through 2020. The Medicare margin for efficient  
2 providers was very high, indicating that Medicare's  
3 payments are too high.

4           This leads us to the draft recommendation, and  
5 I've reworded it slightly so that it matches the structure  
6 of the other recommendations, but its content is the same  
7 as what you discussed in December. It now reads: For  
8 fiscal year 2021, the Congress should eliminate the update  
9 to the fiscal year 2020 Medicare base payment rates for  
10 skilled nursing facilities.

11           The level of Medicare payments indicate that a  
12 reduction would be needed to more closely align aggregate  
13 payments to aggregate costs. However, we expect the SNF  
14 industry to undergo considerable changes as it adjusts to  
15 the redesigned PPS. Given the impending changes, the  
16 Commission will proceed cautiously in considering  
17 recommendations to lower payments. A zero update would  
18 begin to align payments with costs while exerting pressure  
19 on providers to keep their cost growth low.

20           In terms of implications, spending would decrease  
21 relative to current law by between \$750 million and \$2  
22 billion for fiscal year 2021 and by between \$5 billion and

1 \$10 billion over five years. Given the high level of  
2 Medicare's payments, we do not expect adverse impacts on  
3 beneficiaries. Providers should continue to be willing and  
4 able to treat beneficiaries.

5 And with that, I'll turn this back to Jay for  
6 your vote.

7 DR. CROSSON: Thank you, Carol.

8 So I'll invite questions on any of the material  
9 that's new since the December meeting. Paul.

10 DR. PAUL GINSBURG: I just wanted to thank Carol  
11 and Evan and others for writing the introductory thing to  
12 cover all the post-acute care. I think it was very  
13 effective.

14 DR. CARTER: Thank you.

15 DR. CROSSON: Agree. Seeing no questions we'll  
16 proceed to vote on the recommendation before you. All  
17 Commissioners in favor of the recommendation please raise  
18 your hand.

19 [Show of hands.]

20 DR. CROSSON: All opposed?

21 [No response.]

22 DR. CROSSON: Abstentions?

1 [No response.]

2 DR. CROSSON: It passes unanimously.

3 Now Evan is going to take us through home health.

4 MR. CHRISTMAN: Thank you, Jay. As he mentioned,  
5 we're going to go through home health, and again, as Carol  
6 mentioned, this is a shortened version of the presentation  
7 we gave in December. You have an updated chapter that adds  
8 a few points of interest that were raised by Commissioners.  
9 If you have any questions about that I'll gladly take it.

10 Just as a reminder, Medicare spent \$17.9 billion  
11 on home health services in 2018, and there were over 11,500  
12 agencies. The program provided about 6.3 million episodes  
13 to 3.4 million beneficiaries.

14 Turning to our framework, here is our summary of  
15 the indicators. Most beneficiaries live in an area served  
16 by home health. Episode volume declined slightly. Home  
17 health agencies had significant positive marginal profits  
18 of about 18 percent in 2018.

19 For quality measures, the functional measures we  
20 follow that track improvement in walking and transferring  
21 continued to rise in 2018, although some of this increase  
22 may be attributable to coding practices. The rates of

1 hospitalization or ER use did not change significantly.

2           For access to capital, we see that it is  
3 adequate. Large for-profit home health agencies continue  
4 to expand and acquire new businesses, and the financial  
5 performance of the sector under Medicare is strong, and  
6 these are some of the highest margins you will see for this  
7 cycle. The margins in 2018 were 15.8 percent, and we  
8 estimate that they will be 17 percent in 2020.

9           That brings us to the recommendation. The  
10 recommendation reads:

11           For 2021, the Congress should reduce the calendar  
12 year 2020 Medicare base payment rate for home health  
13 agencies by 7 percent.

14           We would expect that this would be a decrease  
15 relative to current law by \$750 million to \$2 billion in  
16 2021, and over \$10 billion over five years. We expect that  
17 access to care should remain adequate. These lower payment  
18 levels should not affect the willingness of providers to  
19 serve beneficiaries. However, they may increase cost  
20 pressure for some providers.

21           That completes my presentation.

22           DR. CROSSON: Thank you, Evan. We'll now invite

1 questions on anything the Commissioners feel has changed  
2 since the December meeting.

3 [No response.]

4 DR. CROSSON: Seeing none, we will proceed to  
5 vote on the recommendation. All of the Commissioners in  
6 favor of the draft recommendation raise your hand.

7 [Show of hands.]

8 DR. CROSSON: All opposed?

9 [No response.]

10 DR. CROSSON: Abstentions?

11 [No response.]

12 DR. CROSSON: Seeing none, it passes unanimously.  
13 And now we're going to move on to IRFs, and Jamila is going  
14 to -- we've got rapid changes of staff here going on.

15 DR. TORAIN: Good afternoon. Now we will review  
16 the indicators for IRF using the same framework you saw in  
17 other sectors.

18 Here is a reminder of the IRF industry in 2018.  
19 There were about 1,170 IRFs, 75 percent were hospital-  
20 based, only 25 percent of IRFs were freestanding, but these  
21 IRFs tend to be bigger so they accounted for about half of  
22 Medicare discharges.



1           There were about 408,000 stays for 364,000  
2 beneficiaries, and program spending in 2018 totaled \$8  
3 billion, and Medicare accounted for about 59 percent of  
4 IRFs discharges. The average length of stay was 12.7 days  
5 in 2018.

6           In summary of the materials we discussed in  
7 December and were included in your mailing materials, we  
8 found that the IRFs payment adequacy indicators were  
9 positive. With regard to the beneficiaries' access to  
10 care, given that the IRFs' occupancy rate was 66 percent  
11 and beneficiaries can receive care in other settings, IRFs'  
12 capacity appears to be more than adequate.

13           With regard to quality of care, our risk-adjusted  
14 outcome measures have improved slightly over time.

15           With regards to IRFs' access to capital, these  
16 facilities maintain good access to capital markets. The  
17 all-payer margin for freestanding IRFs was a robust 10.7  
18 percent in 2018.

19           With regard to Medicare payments and IRF cost  
20 indicators, they were positive. In 2018, the Medicare  
21 margin was 14.7 percent, and we project a margin of 12.7  
22 percent in 2020.

1           So to summarize, we observe capacity appears to  
2 be adequate to meet demand and that providers should have  
3 an incentive to take more beneficiaries that qualify for  
4 IRF-level care given the strong marginal profits for both  
5 freestanding and hospital-based facilities.

6           That brings us to update for 2021. As we did  
7 last year, the draft recommendation reads:

8           For 2021, the Congress should reduce the fiscal  
9 year 2020 Medicare base payment rate for inpatient  
10 rehabilitation facilities by 5 percent.

11          To review the implications, spending would  
12 decrease relative to current law by between \$750 million  
13 and \$2 billion in 2021, and by between \$5 billion and \$10  
14 billion over five years. We anticipate no adverse effect  
15 on Medicare beneficiaries' access to care given IRFs' high  
16 Medicare margins, although the recommendation may increase  
17 financial pressure on some providers.

18          The draft would also include a reiteration of  
19 2016's recommendations to address concerns about coding and  
20 expanding Medicare's IRFs' high-cost outlier pool.

21          And with that I will turn it back to Jay.

22          DR. CROSSON: Thank you, Jamila. Questions on

1 any changes since the December discussion?

2 [No response.]

3 DR. CROSSON: Seeing none, we will proceed to  
4 vote on the recommendation. All of the Commissioners in  
5 favor of the recommendation please raise your hand.

6 [Show of hands.]

7 DR. CROSSON: All opposed?

8 [No response.]

9 DR. CROSSON: Jon, did you vote? Gotcha. Sorry.  
10 Abstentions?

11 [No response.]

12 DR. CROSSON: Seeing none, it passes unanimously.  
13 Thank you, Jamila. Now Stephanie.

14 MS. CAMERON: I'm back. Now we turn to assessing  
15 payment adequacy and updating payment for long-term care  
16 hospitals.

17 As you'll recall, total Medicare spending on care  
18 furnished in 375 LTCHs was approximately \$4.2 billion in  
19 2018. This total spending accounted for payments for just  
20 over 100,000 Medicare cases. The average Medicare payment  
21 per case was about \$40,000 across all cases, and  
22 approximately \$47,000 across the cases meeting the criteria

1 for payment under the LTCH PPS.

2           In summary of the materials that we discussed in  
3 December and that were included in your mailing materials,  
4 occupancy rates across the industry have decreased  
5 slightly. Although growth in the volume of LTCH services  
6 per beneficiary declined, this decline is in large part  
7 from the implementation of the dual payment rate structure,  
8 and LTCHs admitting more patients meeting the LTCH PPS  
9 criteria, which aligns with the goals of the policy.

10           In terms of quality, unadjusted mortality and  
11 readmission rates appear to be stable, while adjusted  
12 infection rates continue to be lower than expected.

13           The effect of fully implementing the dual payment  
14 rate structure will continue to limit industry growth and  
15 access to capital in the near term. The aggregate margin  
16 for LTCHs with a high share of cases meeting the LTCH PPS  
17 criteria increased to 4.7 percent in 2018. Our projected  
18 margin for these LTCHs in 2020 is 3.7 percent.

19           There is no statutory update for Medicare  
20 payments to LTCHs. However, CMS historically has used the  
21 LTCH market basket as the starting point for establishing  
22 the LTCH update.

1 Therefore, we make our recommendation to the Secretary.

2 The draft recommendation reads:

3           For 2021, the Secretary should increase the  
4 fiscal year 2020 Medicare base payment rate for long-term  
5 care hospitals by 2 percent.

6           This 2 percent update is expected to reduce  
7 federal spending relative to the expected regulatory update  
8 by less than \$50 million in 2021, and less than \$1 billion  
9 over five years, given the current projections of market  
10 basket and productivity. We anticipate that LTCHs can  
11 continue to provide Medicare beneficiaries who meet the  
12 LTCH PPS criteria with access to safe and effective care.

13           And with that I turn it back to Jay.

14           DR. CROSSON: Thank you, Stephanie. Questions  
15 about any material that's changed in the last month since  
16 the December presentation?

17           [No response.]

18           DR. CROSSON: Seeing none, we will proceed to  
19 vote on the recommendation. All of the Commissioners  
20 voting in favor of the recommendation please raise your  
21 hand.

22           [Show of hands.]

1 DR. CROSSON: All opposed?

2 [No response.]

3 DR. CROSSON: Abstentions?

4 [No response.]

5 DR. CROSSON: Seeing none, it passes unanimously.

6 Thank you, Stephanie.

7 DR. CROSSON: Now we are going to turn to the  
8 question of the update for hospice services, and Kim is  
9 going to take us through that material.

10 MS. NEUMAN: Good afternoon. Next, we will review  
11 the indicators of hospice payment adequacy and discuss a  
12 draft recommendation for the fiscal year 2021 hospice  
13 update that also involves a policy to modify the hospice  
14 aggregate cap.

15 The information on payment adequacy that I will  
16 summarize was discussed in detail in your mailing  
17 materials. We revised those materials in response to your  
18 December conversation. For example, Larry, we added the  
19 issue of what is an appropriate benchmark for performance  
20 on the hospice CAHPS survey. Karen, we added information  
21 on hospice quality studies by OIG and GAO. And Brian, we  
22 added more discussion on factors that may lead to

1 differences in length of stay across providers.

2           So a few key facts about hospice. In 2018, over  
3 1.5 million Medicare beneficiaries used hospice services,  
4 including more than half beneficiaries who died that year.  
5 Over 4,600 Medicare hospice providers furnished services to  
6 those beneficiaries, and Medicare paid those hospice  
7 providers about \$19.2 billion.

8           So now turning to our indicators of hospice  
9 payment adequacy, which are strong, in terms of access to  
10 care, the supply of hospice providers continues to grow and  
11 hospice use has increased, with the share of Medicare  
12 decedents using hospice and average length of stay rising  
13 in 2018.

14           Marginal profit was 16 percent in 2017, which  
15 suggests providers have an incentive to accept new Medicare  
16 patients.

17           Quality data are limited. Process measures are  
18 mostly topped out, and performance on the hospice CAHPS  
19 survey was stable in the most recent years.

20           A study by the Office of Inspector General  
21 identified a group of about 300 hospices in 2016, that the  
22 OIG labeled as poor performers, based on survey and

1 complaint data.

2           In terms of access to capital, the continued  
3 growth in the number of providers suggests that capital is  
4 accessible. And as far as margins, for 2017, we estimate  
5 an aggregate Medicare margin of 12.6 percent, and for 2020,  
6 we project an aggregate margin at the same level, 12.6  
7 percent.

8           So next we'll switch gears and talk about the  
9 hospice aggregate cap. As you will recall, the cap limits  
10 the total payments a hospice provider can receive in a  
11 year. The cap is an aggregate limit, not a patient-level  
12 limit. In 2020, the aggregate cap was about \$29,965, and  
13 it is not wage adjusted.

14           As we've observed over the years, hospice margins  
15 increase with length of stay, and we see that in the chart,  
16 as we move from left to right, margins increase as hospices  
17 have more long-stay patients. The margin providers in the  
18 highest length of stay group dip a little bit, and that's  
19 because of the hospice aggregate cap.

20           The hospice aggregate cap reduces payments to  
21 hospices with long stays and high margins. For example, in  
22 2017, we estimate that approximately 14 percent of hospices



1 exceeded the cap, and those providers had a high average  
2 length of stay and a margin of 21 percent before  
3 application of the cap.

4           Because the hospice cap is not wage adjusted  
5 while hospice payments are wage adjusted, more hospices  
6 exceed the cap in high wage index areas than low wage index  
7 areas.

8           So a policy to wage adjust and reduce the cap by  
9 20 percent would improve the equity of the cap across  
10 providers and generate savings by focusing payment  
11 reductions on providers with long stays and high margins.

12           And so this next slide shows our simulation of  
13 the effects of the policy to modify the cap using historic  
14 2017 data, assuming no utilization changes. And we've  
15 discussed, with a cap policy change, the share of hospices  
16 exceeding the cap is estimated to increase the yellow bar  
17 in the chart. These new above-cap hospices are providers  
18 that have long stays and high margins, and they are  
19 disproportionately for-profit and freestanding providers.

20           Many hospices, though, those in the blue bars,  
21 would remain well under the cap and would not experience  
22 payment reductions under the cap policy change.

1           So given the margin in the industry and our other  
2 positive payment adequacy indicators, the analysis suggests  
3 that hospice aggregate payments exceed the level needed to  
4 furnish high-quality care. In other sectors, in this  
5 situation, the Commission has generally considered across-  
6 the-board payment reductions, but, in this case, the  
7 hospice cap policy we just discussed provides an  
8 opportunity to focus payment reductions on a subset of  
9 providers with high margins and disproportionately long  
10 stays.

11           So with that in mind, we have developed a two-  
12 part draft recommendation. The draft reads:

13           The Congress should, for fiscal year 2021,  
14 eliminate the update to the fiscal year 2020 Medicare base  
15 payment rates for hospice, and wage adjust and reduce the  
16 hospice aggregate cap by 20 percent.

17           In terms of implications, the draft  
18 recommendation would reduce spending relative to current  
19 law by between \$750 million and \$2 billion over one year,  
20 and between \$5 and \$10 billion over five years.

21           In terms of beneficiaries and providers, we  
22 expect that beneficiaries would continue to have good

1 access to hospice care, and we also expect that providers  
2 would continue to be willing and able to serve Medicare  
3 beneficiaries.

4           So with that I'll turn it back to Jay.

5           DR. CROSSON: Thank you, Kim. I'd invite  
6 questions from Commissioners on any material that has  
7 changed since December. Marge.

8           MS. MARJORIE GINSBURG: This is just a question  
9 on page 62 of the report. It says this would lead to  
10 savings for beneficiaries and taxpayers. I'm not sure how  
11 it would lead to savings for beneficiaries. Taxpayers,  
12 yes, but I wasn't sure what the reference was to  
13 beneficiaries.

14           MS. NEUMAN: In this case, since the Medicare  
15 program pays almost the full chunk, right -- there's very  
16 limited cost-sharing -- I think you're right. We should  
17 change that to focus on taxpayers. Thanks.

18           DR. CROSSON: Good pick-up there. Okay. Other  
19 questions? Karen. Comment?

20           DR. DeSALVO: Thank you guys so much for the  
21 work. I'm supportive of the recommendation. I just wanted  
22 to underline something that's come up in the conversations

1 about hospice as we've had it, which is that there seems to  
2 be a new type of service or benefit that Medicare program  
3 can't necessarily meet for people who have cognitive issues  
4 or neurological disorder.

5           And so I'm not going to presume to put it on the  
6 work plan for next year, but it would be important, I  
7 think, to start thinking about as the epidemiology has  
8 changed and people are increasingly having neurological and  
9 other kinds of illnesses. We may not have the kind of  
10 services or benefits package that's meeting those needs,  
11 and there may be a little bit of that in there, but I would  
12 just encourage us to consider understanding what are the  
13 needs that maybe we're not meeting that are being used in  
14 the hospice program instead.

15           DR. CROSSON: And how could that otherwise be  
16 met?

17           DR. DeSALVO: Exactly. What should we perhaps  
18 build? I mean, it's a similar theme with home health,  
19 where it started as opposed to acute care, but really, it's  
20 evolving into a primary care, and in some cases a primary  
21 care alternative, as the world has evolved. But in this  
22 case, I think it has a lot to do with beneficiary needs

1 more than technology or practice behavioral issues.

2 DR. CROSSON: Beneficiary and family needs, yes.

3 DR. DeSALVO: Mm-hmm.

4 DR. CASALINO: So understanding that hospice and  
5 home health basically being used as a substitute for  
6 something that should exist but doesn't, to take care of  
7 people with cognitive--

8 DR. DeSALVO: Alzheimer's, other forms of  
9 dementia, dementia, and yeah, neurological disorders. I  
10 mean, it seems to be that's what some of the data is  
11 telling us.

12 DR. CASALINO: Are you aware of proposals of this  
13 kind for what that kind of thing could be?

14 DR. DeSALVO: I'm not, and I'm so hesitant to say  
15 it because it just feels huge to think about creating long-  
16 term care support for Medicare beneficiaries, but I think  
17 the reality is we're probably not meeting the needs of  
18 beneficiaries and families. And as the causes of morbidity  
19 and mortality shift as we get better at treating, you know,  
20 cardiovascular disease, et cetera, people are living longer  
21 and having other issues that we -- the program's not really  
22 seemingly able to meet those needs.

1 DR. CROSSON: And I agree it's reasonable to call  
2 that out because it's what's happening, and also, I think  
3 we've seen the development of for-profit organizations  
4 taking advantage of the situation.

5 DR. NAVATHE: It might be interesting. I don't  
6 know that this would be fruitful but to go and look through  
7 like PTAC proposals and see if there's anything that might  
8 be trying to address some of these needs.

9 DR. CROSSON: I'm not aware of it, but it's  
10 possible, yes.

11 Jon?

12 DR. PERLIN: I'm glad Karen brought up the home  
13 health because I was just about to say exactly that.

14 I think not within the body of this work, which I  
15 totally support, but on the difference between the use of  
16 these programs from how they were originally envisioned to  
17 the realities of today is something we really should  
18 address because they're not necessarily bad things.  
19 They're good things.

20 So, for example, the discussion last time about  
21 home health was, I think, very instructive, because in  
22 point of fact, it wasn't really that we're not doing what

1 it was intended to do, provide post-acute care, but we  
2 don't have a mechanism to really support what it might do,  
3 what it is doing in certain circumstances, which is really  
4 pre-acute or preventive care. And that would be a good  
5 thing.

6 DR. CROSSON: Yeah. Broadly speaking, I think  
7 it's our responsibility to point out to the Congress when  
8 we observe that something that was instituted and then  
9 rolled out through CMS has substantively changed, for  
10 better or worse.

11 DR. DeSALVO: Is it too difficult to do that in  
12 this chapter to sort of signal that perhaps there may be  
13 some people who are not using -- some for-profits, rather,  
14 who are not using the program properly, but that perhaps  
15 it's a signal that there are some unmet needs for  
16 beneficiaries, or is that -- is it a little too late to  
17 signal that in the chapter?

18 DR. MATHEWS: We've consistent in both this  
19 chapter and the home health chapter over the years used  
20 phrases along the lines of they're becoming a "de facto  
21 long-term care benefit." But the clause that usually  
22 follows that phrase is "in a way that was not intended when

1 the benefits were established."

2           What you're asking for is a little bit different,  
3 and this might be something we need to think about in one  
4 of our future planning sessions.

5           DR. CROSSON: Kathy?

6           MS. BUTO: I think this reminds me of a  
7 conversation that we had with disability advocates about  
8 the Medicare benefit, some years ago, and the fact that  
9 they actually said, "Look, we know there's a cost issue.  
10 We aren't trying to redesign the benefit to be long-term  
11 care necessarily." But is there a way to think about  
12 different benefit packages that beneficiaries could opt  
13 into? You might be able to do it in the context of a per  
14 member per month kind of Medicare, special Medicare  
15 Advantage kind of thing for people with dementia or  
16 Alzheimer's, for people with -- but it has to be you've got  
17 to cross that bridge of medical versus social and support  
18 services.

19           So I think it's a bold and sort of really big  
20 issue but one the Commission obviously has some appetite to  
21 delve into.

22           But I would throw disability into that bucket.



1 They've been after it for a while and actually engaged in a  
2 demonstration program to see about some sort of capitated  
3 benefit that would allow them to make decisions about the  
4 right mix of, say, personal care, medical, and other  
5 support services.

6 DR. CROSSON: Yes, Pat.

7 MS. WANG: Since I have been on the Commission,  
8 the landscape report on Medicare that gets produced every  
9 year, I have always been struck by that table that says in  
10 2000 whatever, you know, these were the top ten conditions  
11 experienced by Medicare beneficiaries, and this is today.  
12 Since I've been here, Alzheimer's and dementia has been on  
13 the second table but not on the first. Along these lines,  
14 it might be a good idea even to think about in that report  
15 noting that fact because this is -- really, this is a huge  
16 issue for the Medicare program, and it could sort of give a  
17 foundation for future discussions.

18 I have thought -- and I haven't said anything,  
19 but I have always been struck by that and wondered what is  
20 the Medicare program doing to prepare for this. It could  
21 lay a little bit more of a foundation for future  
22 discussions.

1 DR. CROSSON: Thank you.

2 Jon?

3 DR. PERLIN: I'm glad we're having this  
4 conversation because it really highlights the difference  
5 between sort of unnecessary rigidity to prevent abuse,  
6 abuses, versus creative solutions. I just think, to the VA  
7 experience -- for example, VA has a program that's very  
8 robust called the Caregiver Support Program, wherein family  
9 members receive a stipend so that essentially the de facto  
10 employment is the care of a dependent, often a dependent  
11 elder.

12 What is notable about that is that that's a  
13 substitute for not only potentially more expensive services  
14 but potentially less desirable services that disrupt the  
15 family unit as it is.

16 DR. CROSSON: Okay. Good thoughts for future  
17 work.

18 Seeing no further comments -- yes, Marge.

19 MS. MARJORIE GINSBURG: I'm sorry. I have one  
20 other comment about the recommendations. I had originally  
21 written that it was unclear in the writing whether you were  
22 talking about one recommendation or two, and now I see that

1 you've separated them.

2           So my question is I see these as two very  
3 different standalone recommendations that aren't  
4 necessarily linked. Is it to our advantage to present them  
5 as two separate entities or two parts of one?

6           DR. MATHEWS: Let me make a run at that.  
7 Thinking about consistency with the payment adequacy  
8 indicators across the sectors where we look at access,  
9 quality, financial performance, when we look at the  
10 preponderance of the indicators for hospice, we as a  
11 Commission might be in a position where we would say an  
12 across-the-board 3 percent reduction in payment rates is  
13 warranted, and we're looking at minus 5 for home health --  
14 or I'm sorry -- minus 5 for IRF, minus 7 for home health.  
15 Again, there's a little bit of magic here, but if we were  
16 to come up with that kind of update recommendation, that  
17 might be where we are talking about for hospice.

18           But as Kim said, in this instance, we happen to  
19 have a corresponding policy related to the cap that  
20 produces roughly 2.8 percent savings, and so it achieves  
21 the same goal in terms of reducing the amount of dollars  
22 that are going into the hospice sector, but it does so in a

1 much more targeted way than an across-the-board payment  
2 reduction would.

3           As Kim said, it's going to be taken out of the  
4 hospices with the longest length of stay, which happen to  
5 be the ones that are most profitable under Medicare's  
6 payment system.

7           So, in my mind at least, these are integrally  
8 coupled, even though conceptually you are correct. We  
9 could make an update recommendation that could be minus 3  
10 and through the cap thing separately or you could combine  
11 them in the way we've done here.

12           MS. MARJORIE GINSBURG: I just need to hear the  
13 rationale.

14           DR. CROSSON: Good question, Marge.

15           Okay. Seeing no further comments and questions,  
16 we'll proceed to vote on the draft recommendation before  
17 you. All Commissioners in favor, please raise your hand.

18           [Show of hands.]

19           DR. CROSSON: All opposed?

20           [No response.]

21           DR. CROSSON: Abstentions?

22           [No response.]

1 DR. CROSSON: Seeing none, it passes unanimously.

2 Thank you, Kim.

3 And for the last presentation and discussion, we  
4 have Dan her who's going to present ambulatory surgery  
5 centers.

6 MR. ZARABOZO: Right. Okay. So for your updated  
7 chapter on ASCs, we've added some text in response to the  
8 Commissioners' discussion from the December meeting.

9 Bruce, we added a sentence about the number of  
10 ASCs that billed Medicare for at least one surgical service  
11 in 2018.

12 Brian, we enhanced the discussion about the  
13 potential effects of physician ownership of ASCs.

14 And, Dana, we added a comparison of ASC  
15 performance to HOPD performance on poor quality measures  
16 that are in both the ASC quality measure program and the  
17 HOPD quality measure program.

18 Okay. So important facts about ASCs in 2018  
19 include that Medicare fee-for-service payments to ASCs were  
20 nearly \$4.9 billion. The number of fee-for-service  
21 beneficiaries served was 3.5 million, and the number of  
22 Medicare-certified ASCs was about 5,700.

1           Also, the ASC payment rates received an update of  
2 2.6 percent in 2020.

3           In terms of payment adequacy, we find that  
4 beneficiaries' access to ASC services is improving. In  
5 2018, the volume per fee-for-service beneficiary increased  
6 2.2 percent. The number of fee-for-service beneficiaries  
7 served increased 0.9 percent, and the number of ASCs  
8 increased by 2.6 percent. In addition, Medicare payments  
9 for fee-for-service beneficiary increased 7.4 percent.

10           Also, the growth in the number of ASCs suggest  
11 that access to capital has been good. Moreover, there's  
12 been a fair amount of acquisitions and partnerships with  
13 ASCs by corporate entities, which requires access to  
14 capital.

15           On quality, the measures of quality showed  
16 improvement from 2013 to 2017, but we do have some issues  
17 with the quality measures. We believe that CMS should add  
18 more claims-based outcomes measures, and we are concerned  
19 about CMS's decisions to delay the use of a CAHPS-based  
20 patient experience measure.

21           Then, finally, a limitation of our analysis is  
22 that we can't assess margins or other cost-based measures

1 because ASCs don't submit cost data, even though the  
2 Commission has frequently recommended that these data be  
3 submitted.

4           So, once again, we have this draft  
5 recommendation. The Secretary should require ambulatory  
6 surgical centers to report cost data.

7           The importance of this recommendation is that the  
8 Commission has recommended this policy for a decade. At  
9 the same time, CMS has been largely neutral on committing  
10 to collecting cost data from ASCs.

11           Collecting cost data, which Medicare does for  
12 other providers, would improve the accuracy of the ASC  
13 payment system. The Secretary could limit the burden on  
14 ASCs of cost collection by using a streamlined system of  
15 cost submission.

16           Implementing this recommendation would not change  
17 Medicare program spending. We also anticipate no effect on  
18 beneficiaries. However, ASCs would incur some added  
19 administrative costs.

20           To motivate the collection of cost data, we have  
21 a second draft recommendation with slightly different  
22 language from December: "For calendar year 2021, in the

1 absence of cost report data, the Congress should eliminate  
2 the update to the calendar year 2020 conversion factor for  
3 ambulatory surgical centers."

4           Given our findings of payment adequacy and our  
5 stated goals, eliminating this update is warranted. This  
6 is consistent with our general position of recommending  
7 updates only when needed.

8           The implications of this recommendation for the  
9 Medicare program is that it would decrease spending  
10 relative to current law by \$50 million to \$250 million in  
11 the first year and by less than \$1 billion over five years.

12           We anticipate this recommendation having no  
13 effect on beneficiaries' access to ASC services or  
14 providers' willingness or ability to furnish those  
15 services.

16           And now I turn things back to the Commission for  
17 discussion and voting.

18           DR. CROSSON: Thank you, Dan.

19           So are there questions from Commissioners on  
20 anything they feel has changed since December?

21           I see Bruce.

22           MR. PYENSON: Dan, your estimate of under a



1 billion dollars over five years, does that assume a one-  
2 year policy change, and after that, the normal updates  
3 occur?

4 MR. ZARABOZO: Yes.

5 MR. PYENSON: Is how we typically do this sort of  
6 change?

7 MR. ZARABOZO: My understanding is yes.

8 MR. PYENSON: Thank you.

9 DR. CROSSON: Other questions?

10 [No response.]

11 DR. CROSSON: We'll take the recommendations  
12 individually.

13 On the first recommendation, all Commissioners in  
14 favor of the recommendation, please raise your hand.

15 [Show of hands.]

16 DR. CROSSON: All opposed?

17 [No response.]

18 DR. CROSSON: Abstentions?

19 [No response.]

20 DR. CROSSON: Seeing none, it passes unanimously.

21 On the second recommendation before you, all  
22 Commissioners voting in favor, please raise your hand.

1 [Show of hands.]

2 DR. CROSSON: All opposed?

3 [No response.]

4 DR. CROSSON: Abstentions?

5 [No response.]

6 DR. CROSSON: Seeing none, it passes unanimously.

7 Thank you, Dan. That's the end of the agenda for  
8 today.

9 We now have an opportunity for public comment.

10 If any of our guests wish to make a comment, please proceed  
11 to the microphone. I will give you instruction in one  
12 moment. I see several individuals.

13 [Pause.]

14 DR. CROSSON: So this is an opportunity to  
15 provide input to the Commission. It's not the only  
16 opportunity. The staff makes itself available on a regular  
17 basis to individuals and organizations who wish to have  
18 input.

19 Having said that, we do invite you to make a  
20 comment. We would ask you to identify yourself and any  
21 organization you represent, and please limit your comments  
22 to two minutes. When this light goes out, the two minutes

1 will have expired.

2 MS. LESTER: Hi, and thank you. My name is Kathy  
3 Lester. I'm here on behalf of Kidney Care Partners, which  
4 is a coalition of health care providers, nurses,  
5 physicians, other health care providers, dialysis  
6 facilities, manufacturers, and patient advocates. We have  
7 more than 30 members of the kidney care community as  
8 members of KCP.

9 I want to thank the Commission for really looking  
10 at the issues of innovation in the ESRD program. Some of  
11 you had asked the question: has there been innovation in  
12 this sector? And I think if you asked our patient members,  
13 they would say very little. There has been very little  
14 change since the bundle was first created until the '90s  
15 when ESAs came in, and when you saw the discussion of drugs  
16 that were going into the bundle, you were hearing them in  
17 that ESA category.

18 But when you look at the innovation pipeline that  
19 we have, there are very few, but I think those came about  
20 because there was a hope under the new ESRD PPS system.  
21 There would be opportunities to think about adding cost.

22 Nancy raised the issue of the anti-pruritic drug.

1 That may or may not be within a functional category. I  
2 don't think we'll know that until the FDA writes the label  
3 and approves it, but that drug, if it were in, would be  
4 competing against Benadryl.

5           There's less than a dollar in the bundle for that  
6 functional category. So it's hard to see how a new product  
7 that would have such a dramatic impact potentially on a  
8 disease where patients are itching themselves, getting  
9 infections, and now not qualifying for transplants could  
10 compete when there is simply no money in the bundle.  
11 There's no other product or category that could be offset  
12 because there is no other treatment option for the  
13 pruritic.

14           So it's an example of why we think TDAPA was  
15 created, to have a study period, to understand those truly  
16 innovative products, and the community agrees with many of  
17 the conversations and comments you made today. TDAPA needs  
18 to be narrowed. It should focus on drugs that provide  
19 clinical improvement to patients in a substantial way.

20           So we really do encourage you to look at that  
21 patient option. I think one of the Commissioners suggested  
22 looking at the functional categories, seeing what is in

1 there, if there have been changes, what the costs are in  
2 terms of dollars, but also what are the options for patient  
3 outcomes?

4           So, again, very much appreciate your looking at  
5 the issue, and we also agree that looking upstream is where  
6 you're going to find savings in this patient population.  
7 The ESRD program is a one EMSR TRG, and there really aren't  
8 ways to shift across that.

9           So, again, we always thank you for your attention  
10 and focus on this area and look forward to future  
11 conversations.

12           DR. CROSSON: Thank you.

13           MS. ACS: Hello. My name is Annie Acs, and I am  
14 the director of Health Policy and Innovation at the  
15 National Hospice and Palliative Care Organization.

16           On behalf of NHPCO and our president and CEO, Edo  
17 Banach, I respectfully submit comments on MedPAC's  
18 recommendation to Congress to wage-adjust and reduce the  
19 hospice aggregate cap by 20 percent.

20           NHPCO is the nation's largest membership  
21 organization for hospice providers and professionals who  
22 care for people affected by serious and life-limiting

1 illness. Our broad community of members include local  
2 hospice and palliative care providers, networks serving  
3 large regions of the United States, individual  
4 professionals, and NHPCO's members provide care in more  
5 than 4,000 hospice and palliative care at locations and  
6 care for over two-thirds of Medicare beneficiaries served  
7 by hospice.

8           In addition, hospice and palliative care members  
9 employ nearly 60,000 professionals and hundreds of  
10 thousands of volunteers.

11           NHPCO notes that with the recommendations  
12 approved today, including increases to hospital payments,  
13 MedPAC is relaying a message to Congress and to all  
14 Americans that they encourage care to be provided in acute  
15 care settings, while discouraging person-centered care in  
16 less costly settings, like in the home or wherever  
17 beneficiaries and their families may consider home.

18           For almost 40 years, hospice has demonstrated  
19 value to both the Medicare program, and today more than  
20 half of all Medicare decedents received hospice care.

21           With more Americans choosing to die at home, we  
22 must prioritize payment for home-based care. As we have

1 previously stated, the recommended modifications to the  
2 hospice aggregate cap will negatively impact access to care  
3 and potentially drive people to more expensive care  
4 settings.

5           We are especially concerned for people living in  
6 rural and underserved areas, as we have heard from hospice  
7 providers across the nation that these dramatic cuts could  
8 result in unintended hospice closures, particularly in low-  
9 wage index and underserved areas.

10           We strongly believe that structural reforms to  
11 the hospice benefit, including value-based payments, should  
12 be explored in future MedPAC discussions. Today's  
13 recommendations are not structural and are not targeted to  
14 improve quality.

15           DR. CROSSON: Please conclude your remarks.

16           MS. ACS: Thank you.

17           On behalf of NHPKO, I thank you for your service,  
18 and we will continue to offer our assistance to MedPAC in  
19 your important role in advising Congress.

20           Thank you.

21           DR. CROSSON: Okay. Seeing no other speakers at  
22 the microphone, we are adjourned until 8-30 tomorrow

1 morning.

2           Thank you to all the staff. Thank you to  
3 Commissioners.

4           [Whereupon, at 4:52 p.m., the meeting recessed,  
5 to reconvene Friday, January 17, 2020, at 8:30 a.m.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom  
Ronald Reagan Building  
International Trade Center  
1300 Pennsylvania Avenue, NW  
Washington, D.C. 20004

Friday, January 17, 2020  
8:29 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair  
PAUL GINSBURG, PhD, Vice Chair  
KATHY BUTO, MPA  
LAWRENCE P. CASALINO, MD, PhD  
BRIAN DeBUSK, PhD  
KAREN B. DeSALVO, MD, MPH, Msc  
MARJORIE E. GINSBURG, BSN, MPH  
DAVID GRABOWSKI, PhD  
JONATHAN B. JAFFERY, MD, MS, MMM  
AMOL S. NAVATHE, MD, PhD  
JONATHAN PERLIN, MD, PhD, MSHA  
BRUCE PYENSON, FSA, MAAA  
JAEWON RYU, MD, JD  
DANA GELB SAFRAN, ScD  
WARNER THOMAS, MBA  
PAT WANG, JD

AGENDA

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1 P R O C E E D I N G S

P R O C E E D I N G S

[8:29 a.m.]

3 DR. CROSSON: Good morning, and we welcome our  
4 guests to the Friday morning meeting of MedPAC for its  
5 January session.

6           This morning we have two items of business. The  
7 first one will be the likely conclusion to a body of work  
8 that's been going on for a year or so in response to a  
9 specific set of questions that we were provided by Members  
10 of Congress, and we have Kim and Nancy and Shinobu here,  
11 and Kim is going to begin. Thanks.

12 MS. NEUMAN: Good morning. As you'll recall,  
13 in August 2018 the Chairman of the Committee on  
14 Energy and Commerce asked MedPAC to develop a report on two  
15 topics: the first was hospital consolidation and physician  
16 integration, and the second was hospital financial  
17 incentives under the 340B drug pricing program. The  
18 mailing materials you received for this session covers both  
19 topics.

Findings on the first topic, consolidation, were presented at the November Commission meeting. The section of the mailing materials on consolidation is similar to

1 November and includes updates to reflect your conversation  
2 at the meeting.

3           Work on the second topic related to the 340B drug  
4 pricing program is new and will be the focus of our  
5 presentation today.

6           Specifically, we have been asked to examine  
7 whether the 340B drug pricing program creates incentives  
8 for hospitals to use more expensive drugs and the  
9 implications for beneficiary cost sharing.

10           Before we get started, I would like to thank  
11 Jeff, Dan, and Rachel for their contributions to this work  
12 on 340B. In addition, I'd like to note that Acumen LLC  
13 performed work under contract for this project.

14           So first some background on how the 340B program  
15 works and how Medicare pays for drugs.

16           The 340B program offers nonprofit hospitals that  
17 serve a large share of low-income patients the opportunity  
18 to purchase outpatient drugs at substantially discounted  
19 prices.

20           Manufacturers are required to sell drugs to 340B  
21 hospitals at a price no greater than the 340B ceiling  
22 price. The ceiling price is discounted in two ways. There

1 is a basic rebate, which you can generally think of as a  
2 percentage discount -- 23 percent for brands and 13 percent  
3 for generics.

4           In addition, the ceiling price also incorporates  
5 an additional discount, referred to as "the inflation  
6 rebate," when a product's price has increased faster than  
7 inflation over time. With the inflation rebate, the more a  
8 product's price increases over time, the greater the  
9 discount a hospital receives.

10           Medicare Part B covers drugs administered in  
11 physician offices and outpatient hospitals, including drugs  
12 furnished by 340B hospitals.

13           Medicare generally pays for Part B drugs based on  
14 the manufacturer's average sales price, or ASP. This is an  
15 average price across purchasers and does not reflect 340B  
16 discounts.

17           Before 2018, Medicare paid outpatient hospitals  
18 the same rate regardless of whether they participated in  
19 the 340B program, generally ASP+6 percent.

20           When Medicare paid 340B hospitals the same  
21 payment rate as other hospitals, 340B hospitals earned  
22 substantial profit margins because they purchased drugs at

1 heavily discounted prices.

2           Beginning 2018, Medicare lowered the payment rate  
3 for 340B hospitals for some Part B drugs to ASP-22.5  
4 percent. That reduced rate reduces but not necessarily  
5 eliminates the profit margin 340B providers earn on Part B  
6 drugs.

7           Although the mechanics of payment for drugs work  
8 differently under Part D, some hospitals earn rebates on  
9 Part D drugs dispensed through in-house or contract  
10 pharmacies.

11           So how might the 340B program influence  
12 prescribing patterns?

13           First, 340B hospitals may face incentives to  
14 select higher-priced drugs. This could occur if expensive  
15 drugs offer 340B providers greater margins than less  
16 expensive therapeutic alternatives.

17           Because of the way the 340B ceiling price is  
18 structured with a basic rebate and an inflation rebate,  
19 higher-priced products may offer providers a higher margin,  
20 but it's not necessarily always the case. Nancy will  
21 discuss more of what's known empirically about this  
22 shorting.

1           A second way the 340B program could influence  
2 spending is by creating incentives to furnish more drugs.  
3 The availability of discounts on a wide range of drugs for  
4 340B providers could encourage the use of more drugs in  
5 general.

6           MS. RAY: Empirical evidence on 340B effects on  
7 drug prescribing, including whether it leads to the use of  
8 more costly drugs, is limited.

9           The OIG used the 340B ceiling price to look at  
10 the profitability of drugs furnished by 340B hospitals and  
11 found that among five cancer drugs, some lower-priced drugs  
12 offered higher margins (defined here as the difference  
13 between a drug's Medicare payment and its 340B ceiling  
14 price) than higher-priced drugs and that some higher-priced  
15 drugs offered higher margins than lower-priced drugs.

16           For example, Drug 2 had a lower Medicare payment  
17 amount but a greater margin than Drug 1. Whether there  
18 were financial incentives to use these five products would  
19 depend on which, if any, of these products were therapeutic  
20 alternatives for one another. The OIG report does not  
21 provide information on the names of the products or whether  
22 they are alternatives for one another.

1           Other studies have focused on differences in drug  
2 spending between 340B and non-340B entities. These studies  
3 have generally found higher drug spending among 340B  
4 entities compared to non-340B entities.

5           For example, GAO found that in 2012, per  
6 beneficiary spending for cancer drugs was 44 percent  
7 greater at 340B DSH hospitals compared to non-340B DSH  
8 hospitals. GAO concluded that neither health status nor  
9 hospitals' teaching status accounted for the higher cancer  
10 drug spending at 340B hospitals.

11           However, some stakeholders have critiqued this  
12 and other studies for not sufficiently controlling for  
13 patients' characteristics. GAO's study did not include  
14 Part D spending, and it did not examine 340B effects by  
15 cancer type.

16           MedPAC's analysis addresses the question of  
17 whether 340B status is associated with higher cancer drug  
18 spending. We could not replicate the OIG analysis because  
19 we do not have access to the 340B ceiling price. We focus  
20 on cancer because it accounts for three quarters of  
21 outpatient drug spending.

22           A couple of key points about our analysis:



1           We look at average cancer drug spending per month  
2 for patients with a cancer diagnosis. We are, we believe,  
3 the first researchers to include both Part B and Part D  
4 spending.

5           We conduct our analysis by type of cancer since  
6 drug regimens and spending differ by cancer type. Our  
7 analysis includes the five different cancer types listed on  
8 this slide.

9           We include in our analysis cancer patients  
10 treated across several settings -- 340B hospitals, non-340B  
11 hospitals, and physician offices. And our analysis covers  
12 the pre-2018 period when 340B hospitals were generally paid  
13 ASP+6.

14           We found that the cancer type influences drug  
15 spending. Among the five cancer types, average drug  
16 spending ranged from \$1,800 per beneficiary per month for  
17 prostate cancer to \$5,200 per beneficiary per month for  
18 leukemia and lymphoma.

19           Spending varies less by location of care than  
20 type of cancer. Compared to non-340B hospitals, average  
21 cancer drug spending at 340B hospitals was 2 to 5 percent  
22 higher. We found mixed results comparing 340B versus

1 physician offices. With the exception of prostate cancer,  
2 spending at 340B hospitals ranged from 1 percent lower to 7  
3 percent higher compared to physician offices.

4           For prostate cancer, spending at 340B hospitals  
5 was roughly 70 percent greater than at physician offices.  
6 This difference may stem from differences in the mix of  
7 drugs.

8           Like other researchers, we found that 340B  
9 providers are larger and more likely to be teaching  
10 hospitals. We also found that 340B hospitals are more  
11 likely to treat cancer patients that are young, disabled,  
12 receive Part D LIS, and are duals compared to other  
13 providers.

14           MS. SUZUKI: Data shows that 340B hospitals have  
15 higher drug spending, but they also differ from other non-  
16 340B hospitals, and those differences may explain some or  
17 all of the difference in spending.

18           Our task was to determine if the 340B discounts  
19 increased Medicare's spending for cancer drugs without  
20 actually knowing the discount amounts.

21           To do this, we first examined what happens to  
22 cancer drug spending when a hospital newly gains 340B

1 status.

2           For this analysis, we compared spending patterns  
3 of hospitals that gained 340B status between 2013 and 2017  
4 with those that either remained 340B in both years or were  
5 never 340B.

6           The main conclusion here is that we found no  
7 consistent pattern among new 340B hospitals relative to  
8 others, so this suggests that 340B discounts may not have  
9 had any effect on them.

10           There are a few caveats. The sample size is  
11 relatively small, and depending on the timing of the status  
12 change, the time period we examined may not fully capture  
13 the effects of the status change.

14           The second question we asked is what happens to  
15 cancer drug spending when more patients are treated at 340B  
16 hospitals.

17           Results from our regression analysis suggest  
18 modest effects for some cancer types, which I'll come back  
19 to in a minute.

20           The model we used looked at average Part B and D  
21 cancer drugs spending at the MSA level. This approach  
22 allows us to address potential patient selection by 340B

1 status. We also adjusted for the effects of provider  
2 consolidation.

3           We ran separate regression for the five cancer  
4 types, and the key variables are 340B market share, defined  
5 as the share of patients treated by 340B entities, and HOPD  
6 market share, defined as the share of patients treated by  
7 any hospital, meaning either 340B and non-340B.

8           Including both of these market share variables  
9 allows us to separate the changes in cancer drug spending  
10 attributable to expansion of 340B market share from the  
11 effect of overall increase in hospital market share.

12           Other variables include general trends in  
13 oncology drug spending, patient demographics, and other  
14 systematic differences across MSAs.

15           This table summarizes the main findings from the  
16 regression analysis.

17           The effects of 340B market share was  
18 statistically significant for two out of five cancer types,  
19 prostate and lung cancer. The estimated effects were about  
20 \$300 per patient month. In 2013, that translates to a  
21 difference of about 28 percent for prostate cancer and 11  
22 percent for lung cancer.

1           The effect of HOPD market share, on the other  
2 hand, was not statistically significant in any of the  
3 cancer types. The implication here is that the increase in  
4 hospital market share did not affect spending for the  
5 specific cancer types we examined.

6           We did find that effects of general trend in  
7 oncology drug spending, which reflects both increase in the  
8 prices of existing products and new product launches, to be  
9 statistically significant in all cancer types. Being  
10 younger also had large and statistically significant  
11 effects on spending for most cancer types.

12           Reasons for high spending at 340B hospitals  
13 appear to be specific to the type of cancer.

14           When we took a closer look at spending for lung  
15 cancer patients, we found that average Part B drug spending  
16 was higher at 340B hospitals than at other settings, and  
17 that difference was partly due to the greater use of the  
18 new immune-oncology products at 340B hospitals.

19           For prostate cancer, we found that prices at 340B  
20 hospitals were higher for both Part B and Part D drugs,  
21 suggesting differences in the mix of drugs used. We also  
22 found that patients treated at 340B hospitals used more

1 Part D medications than patients in other settings.

2 But as we noted earlier, we are unable to  
3 attribute these findings specifically to incentives created  
4 by 340B discounts because we lack access to the discount  
5 data and the magnitude of discounts are not necessarily  
6 proportionate to the prices, as shown by the OIG study.

7 Here are the key takeaways:

8 We found evidence of higher drug spending at 340B  
9 hospitals for some cancer types, but other effects, like  
10 the general trend in oncology drug spending, tended to be  
11 larger.

12 We also found that effects on cancer drug  
13 spending are likely to be idiosyncratic and not  
14 generalizable to other cancer types or conditions.

15 Overall effects on beneficiary cost sharing for  
16 cancer drugs is likely to be small, if any, depending on  
17 the type of cancer and the patient's supplemental coverage.

18 For discussion today, we will address the  
19 questions you have on our presentation as well as any  
20 questions or comments on the revised content on from  
21 November.

22 We look to you for guidance on finalizing this

1 report.

2 DR. CROSSON: Okay. Thank you, Nancy, Kim, and  
3 Shinobu.

4 Let's open for clarifying questions. Brian.

5 DR. DeBUSK: First of all, great report, love the  
6 analytics. The regressions were impressive.

7 Could you speak to or help me understand the  
8 other sources of discounts, for example, a Medicaid  
9 discount? It seems like we're using the price of the drug  
10 in the regression, not necessarily the margin. Are there  
11 other sources of discounts that could be generating margins  
12 that would create competing incentives here?

13 MS. SUZUKI: So, I mean, to the extent that on  
14 the Part D side plan formularies are driven in part by  
15 rebate and tiers, that may have some impact on which drugs  
16 are filled by beneficiaries.

17 DR. DeBUSK: Are there in general other sources  
18 of discounts, I guess, that could compete -- that could  
19 create competing interests? Let me reframe the question.

20 MS. NEUMAN: Are you speaking specifically with  
21 regard to 340B hospital or all providers?

22 DR. DeBUSK: All providers in general.

1 MS. NEUMAN: All providers in general. So, you  
2 know, providers have the potential to purchase drugs  
3 sometimes with discounts and rebates, and they're paid  
4 based on average sales price. So we know that some  
5 providers get bigger discounts than others. So we would  
6 expect in the physician office, for example, from there to  
7 be variation in purchase prices across providers, so some  
8 providers might have more or less margins than others.

9 I would say in general we would not -- not being  
10 able to see the data, the 340B ceiling prices, that's the  
11 caveat. But, in general, I would say that we would not  
12 expect other providers to generally have discounts of the  
13 size that 340B providers --

14 DR. DeBUSK: Okay. So if you qualify for 340B,  
15 it's safe to assume the discounts you receive are  
16 overwhelming to any other potential source of discounts,  
17 say a group purchasing organization or some other discount  
18 you may get?

19 MS. NEUMAN: In general, we think that's --

20 DR. DeBUSK: Okay. Good. Thank you.

21 DR. CROSSON: Jaewon and Kathy.

22 DR. RYU: Hi. Thanks for the analysis. I know



1 that you had mentioned that the analysis was really based  
2 on the pre-2018 change, and I think that's because we don't  
3 have a full experience since the change. But given that  
4 the effect is fairly nominal, it sounds like there's some  
5 evidence but it's not huge, if I can kind of summarize it,  
6 and then in '18 with the ASP-22.5, is it a fair assumption  
7 to sort of, if we had to guess, it seems like that should  
8 remove any differential that could be there? Is that fair?  
9 Is that too far of a leap?

10 MS. NEUMAN: So for brand drugs, there's the  
11 basic rebate, which is generally 23 percent. So you can  
12 think of the payment cut as kind of washing away the basic  
13 rebate, but there is still an inflation rebate component to  
14 the ceiling price. And for some products, that is quite  
15 large, and for others it may not have it at all. And so I  
16 would say there's probably variability across products in  
17 the extent to which they have substantial margins.

18 DR. RYU: So after the 2018 change, to the extent  
19 there's an inflationary driver of some of this dynamic,  
20 that would still be in place.

21 MS. NEUMAN: Right.

22 DR. RYU: Okay.

1 MS. NEUMAN: And then I would just note one other  
2 thing. It was on the slide, but we didn't talk about it.  
3 Currently, passthrough drugs are paid ASP+6 percent even  
4 under current law, so they're still subject to the same  
5 dynamic that existed prior to 2018.

6 DR. RYU: And that's just for the, whatever, two  
7 years that they have passthrough status.

8 MS. NEUMAN: Two to three years, yes.

9 DR. RYU: Thank you.

10 DR. CROSSON: Kathy.

11 MS. BUTO: Let's see. I've got a couple of  
12 questions. One of them is, since the old drugs, I think,  
13 get bigger discounts, especially because of the inflation-  
14 related rebate, do we know anything about the mix of older  
15 versus newer drugs in 340B hospitals? Any sense of that?

16 MS. SUZUKI: So, in general, this is just  
17 eyeballing by 340B versus non-340B hospitals.

18 The drugs that are used for specific cancer types  
19 are generally similar, and looking at the spending, ranked  
20 by spending, they're not terribly different. So we find  
21 that the choice of drugs used in those two settings are not  
22 very different for a given cancer.

1 MS. BUTO: Okay. So the newness and the extent  
2 of the rebates related to inflation don't seem to be a  
3 major factor is what I hear you saying.

4 Then the other two questions I had were -- and  
5 this may have been in the paper, and I just missed it. How  
6 much do we know about how the 340B drug, I guess, payment  
7 to cost differential has contributed to hospital margins?  
8 Do we have any sense of that? I have a feeling you've  
9 dealt with that, but I cannot remember.

10 DR. JAFFERY: Maybe an extra percent increase in  
11 the margins or 2 percent, maybe, and then in 2018, though,  
12 remember then they took that 22.5 percent away.

13 MS. BUTO: Right.

14 DR. JAFFERY: And they distributed it across all  
15 the different outpatient services.

16 MS. BUTO: Services, yeah.

17 DR. JAFFERY: So what that actually did is, in  
18 2018, we saw a little bit of a reversal. So that if you  
19 were a non-340B, you did better in 2018 because they took  
20 some money away from the 340B and distributed it to you and  
21 everybody else.

22 MS. BUTO: Okay.

1 DR. JAFFERY: So we see the 340Bs doing better  
2 initially, and then in 2018, we see like probably a 1  
3 percent bump-up for for-profits and other people that  
4 weren't getting the 340B because they redistributed some of  
5 the 340B money.

6 MS. BUTO: Okay. And is that discount still in  
7 effect? I know it's being challenged in court.

8 DR. JAFFERY: Yeah. The discount is still in  
9 effect, but they're litigating over whether you can  
10 actually take that discount and redistribute it across  
11 everybody.

12 MS. BUTO: Okay. So they're not questioning  
13 whether the 22 percent or so can be taken away. It's  
14 whether or not it can be redistributed to other services.

15 DR. JAFFERY: That's my understanding.

16 DR. ZABINSKI: [Speaking off microphone.]

17 MS. BUTO: They don't like it.

18 And then the last question I had was -- and,  
19 again, I'm pretty sure you've dealt with this, but I could  
20 not find it -- the extent to which we have seen a major  
21 shift in oncology care from the physician office to OPDs as  
22 a result of 340B. Do you have that, a sense of that?

1 Because that then leads to the issue of higher cost to the  
2 program, potentially.

3 MS. NEUMAN: So I have some data that's specific  
4 to lung cancer that I can provide for you now. We could  
5 put something broader in the paper.

6 For lung cancer, what we see is that about  
7 roughly 40 percent of patients were treated in hospitals in  
8 2009, and by 2017, that was about 60-ish percent. And  
9 roughly, two-thirds of that 60 was 340B. So that gives a  
10 little bit of a sense.

11 MS. BUTO: And then the dilemma I have is I know  
12 to the program, which is still paying ASP+6 for many of  
13 these drugs, the cost of the drug is not measurably  
14 different from the physician's office, but it's the other  
15 services that go along with that, that would increase cost  
16 to the program. So I think just a sense of what that  
17 change has been is helpful as we think about it.

18 Thank you.

19 DR. CROSSON: Jim?

20 DR. MATHEWS: Yeah. Kathy, if I could just jump  
21 in here, and, Kim, if you can give me a gut check on this.  
22 We have observed the shift in setting that Kim just

1 described, but I do not think we have specifically  
2 attributed that effect to the 340B program per se. That  
3 over the years, we've observed general trends in the  
4 migration of services -- cardiology, to some extent  
5 oncology, orthopedics from the office setting to OPDs. But  
6 we've attributed this more towards the payment differential  
7 and not specifically 340B. Is all of this reasonably  
8 correct? Yeah, okay. Thanks.

9 MS. BUTO: You reminded me of something else.  
10 Were you surprised to see that there were DSH hospitals  
11 that were not 340B hospitals? That surprised me.

12 MS. NEUMAN: Criteria that you have to meet, you  
13 have to be nonprofit, and there's certain criteria about  
14 your share of low-income patients and so forth.

15 MS. BUTO: Great. Thank you.

16 DR. CROSSON: Amol?

17 DR. NAVATHE: I have a couple of simple, quick  
18 comments, and then I can go on to the question.

19 One thing is, on page 17 of the writeup in the  
20 hospital consolidation piece, I think you're missing a  
21 "not." It says "while individual hospitals under financial  
22 strain may consolidate this hypothesis does account." I

1 think you want "does not." Just a mundane point.

2           The other mundane point was I think the Desai et  
3 al. reference is missing from the bibliography.

4           And then the real question I had was on Slide 10,  
5 if it's possible to go to that slide. Just to understand  
6 exactly what's happening here, I was curious. Do you guys  
7 have a sense of what are the characteristics of the  
8 hospitals that are gaining, newly gaining 340B status? In  
9 part, the reason I ask this question is because I think it  
10 will help us in interpretation. You outlined just now a  
11 couple of the criteria around low income and DSH payments  
12 and such to get 340B status, but in some sense, this  
13 comparison would be most helpful if interpreted as the  
14 obtaining of the 340B status was not anticipated and/or not  
15 deliberate on the part of the hospital. But I wonder what  
16 you guys think about that assumption that would actually  
17 help us understand what the differences are. Otherwise, it  
18 may be actually quite hard to interpret this analysis in  
19 terms of obtaining the 340B status and what it really  
20 means.

21           DR. PAUL GINSBURG: While they're thinking about  
22 it, wouldn't you think that all hospitals would like to

1 obtain 340B status? I don't know that there would be a  
2 simultaneity problem.

3 DR. NAVATHE: Well, I think the issue is that if  
4 we're looking at hospitals that gain 340B status and then  
5 say effectively pre/post for them, what changes, if they're  
6 anticipating or if they're doing other things to gain 340B  
7 status, then they may change their behavior much in  
8 advance, and the actual pre/post wouldn't really be that  
9 helpful.

10 DR. CROSSON: It seems to me it's been a few  
11 years now, but when we were talking about formulating our  
12 own 340B policy, I think our analysis suggested that at  
13 least some of these hospitals were obtaining 340B status  
14 through horizontal consolidation. Is that not the case?

15 DR. NAVATHE: Yeah. That's part of my worry here  
16 is that they're deliberately also doing this. So, in that  
17 case, why not, quote/unquote, "ramp up" your spending while  
18 you know you're going to get that status because you're  
19 doing other activities? And that would confound this  
20 analysis.

21 DR. CROSSON: Before we go on, does someone want  
22 to answer?



1 MS. SUZUKI: So just a couple of things. So the  
2 newly 340B hospitals were on average smaller than the 340B  
3 hospitals. They were also older hospitals -- older  
4 patients. I'm sorry. And I don't know that we have a lot  
5 of information about whether the demographics differed for  
6 these hospitals, but we can definitely take a look and get  
7 back to you on other differences.

8 DR. NAVATHE: I think what might also be helpful,  
9 if I may, is to see if there was any -- to Jay's point, any  
10 other sort of consolidation activity that preceded getting  
11 this status or if we can understand how they gained the  
12 340B status, and in particular, if we could look at the  
13 criteria for 340B status and look in the pre-period to  
14 understand, effectively, how close were they or how not  
15 close were they, I think it would give us a little bit of  
16 information around who this population of hospitals are and  
17 to what extent this is sort of like a windfall, "Oh, look,  
18 we hit 340B status," and then this analysis is more  
19 helpful, or we deliberately tried to get 340B status  
20 through some activities and this analysis would be a little  
21 bit more -- we might want to interpret it a little bit more  
22 cautiously.

1 DR. CROSSON: Pat, are you on this point?

2 MS. WANG: I can't comment on the analytical  
3 pieces of it, but I do wonder about changes in the  
4 environment that might have qualified more hospitals for  
5 340B status, including the Medicaid expansions that came  
6 about as a result of the ACA, because as I recall, Medicaid  
7 in patient share is a criteria for determining 340B status.

8 I think there may be different things going on in  
9 the environment in addition or, you know --

10 DR. NAVATHE: That's great. That would be  
11 tremendously helpful for us to describe, then. That piece  
12 itself would potentially truly exogenous or close to  
13 exogenous and would help us interpret these results more  
14 strongly.

15 Thanks, Pat.

16 DR. CROSSON: Great.

17 Paul?

18 DR. PAUL GINSBURG: Yes. You mentioned that 340B  
19 hospitals are much more likely to be teaching hospitals  
20 than nonteaching hospitals, and I would imagine for cancer  
21 or maybe many treatments, a teaching hospital would have a  
22 different treatment pattern. So I was wondering if in your

1 regression that you could hold teaching constant or some  
2 other tabular thing just so cross tab with teaching,  
3 nonteaching.

4 MS. SUZUKI: So in our regression model at the  
5 MSA level, we did control for teaching status in the MSA.

6 DR. PAUL GINSBURG: Oh, good.

7 DR. CROSSON: Larry?

8 DR. CASALINO: This is my question, but just to  
9 follow up to what was just said, control for teaching  
10 status and patient case mix, correct as much as you could.  
11 In the regression, you can control for teaching status and  
12 some measures of patient health.

13 MS. SUZUKI: So we did try running a couple of  
14 versions, and demographics was one of them. It's hard to  
15 control for the severity of the specific cancer, but by  
16 selecting individual cancers and running separate  
17 regressions, we try to control for the condition of the  
18 patient.

19 DR CASALINO: Yeah. Cancer is particularly  
20 difficult for that reason, I think.

21 My question is, to my knowledge, every study of  
22 provider behavior, although this is mostly about

1 physicians, shows that when they have strong incentive,  
2 financial incentive to do something, they do more of it.  
3 So these results are a little surprising because they're  
4 not that strong.

5           I wonder if there's another step that could be  
6 done. So hospitals don't order drug treatments.  
7 Physicians do; in this case, oncologists. And you could  
8 hypothesize that oncologists who are employed by a hospital  
9 might -- if there is going to be a response to this 340B  
10 incentive, could I hypothesize that oncologists that are  
11 employed by a hospital might behave differently than  
12 oncologists who were treating patients in the hospital but  
13 not employed by the hospital? And, you know, if there's  
14 going to be an effect, you would expect to see more of an  
15 effect with the oncologists who are employed. Would it be  
16 possible for you to -- it's not that easy to tell who's  
17 employed by a hospital, necessarily, but I wonder if it  
18 would be possible for you to try to look at that to see if  
19 it's also different if you looked just at hospitals where  
20 the oncologists are employed.

21           MS. SUZUKI: We'll look into this, but we're not  
22 sure whether that's something that we could do on a short

1 term. But we'll take a look.

2 DR. PAUL GINSBURG: Larry, these are all  
3 outpatients, and wouldn't you think that the office-based  
4 physicians would be doing this in their office rather than  
5 a hospital and outpatient --

6 DR. CASALINO: Yeah. That's a good question.  
7 I'm not sure. Sometimes yes, but for particularly sick  
8 patients or for certain treatments, they might be using the  
9 hospital as the physician's workshop and still be  
10 independent physicians treating in that hospital  
11 outpatient. I don't actually know for sure.

12 DR. PAUL GINSBURG: That would be a very  
13 difficult case-mix adjustment, then.

14 DR. CASALINO: Yeah, it would. Yeah.

15 DR. CROSSON: Okay. Bruce and then Pat.

16 MR. PYENSON: Thank you very much.

17 I'm wondering if you could describe the cash flow  
18 process for 340B. My understanding is that there's a  
19 retrospective settlement process. So the actual discount  
20 comes in the form of refund later, later on in the process,  
21 at least for Part D drugs.

22 I didn't see it in the document. I think it

1 would be useful to have that.

2 MS. SUZUKI: We could definitely add information  
3 on the cash flow for Part D drugs. This is through  
4 contracted pharmacies, that sort of thing.

5 MR. PYENSON: Yeah. And sort of the timing of  
6 that and the entities involved in that.

7 MS. SUZUKI: We'll try to provide a little more  
8 information.

9 MR. PYENSON: Oh, thanks.

10 Another question I had was I think I saw that  
11 dedicated cancer centers were not included in the study,  
12 and the question of why or what your thinking was about  
13 that?

14 MS. NEUMAN: They are in the data in the MSA  
15 analysis, cancer hospitals.

16 MR. PYENSON: So it seemed like a PPS, only PPS  
17 hospitals were included?

18 MS. NEUMAN: I think, technically, they fall  
19 under the category of hospitals paid under the OPPS. So  
20 they are in there.

21 MR. PYENSON: Ah, okay. Got it. Thank you.

22 DR. CROSSON: Pat?

1 MS. WANG: I just want to make sure that I  
2 understand the responses to the question that Kathy was  
3 asking about hospital acquisition of physician practices  
4 and Jim's comments. There are a lot of reasons for that to  
5 have happened in the environment, both from the physician  
6 side as well as the hospital side, but did you comment on  
7 and do we know whether we can see that there was more such  
8 activity by 340B hospitals versus non-340B hospitals?

9 MS. RAY: Our study does not look at that.

10 MS. NEUMAN: Are you interested in how the  
11 patients are shifting across sites or more the sort of  
12 acquisitions piece of things?

13 MS. WANG: I guess it's more the acquisitions  
14 piece. It goes to the concern that Kathy raised as a  
15 potential concern with expense of a physician's office  
16 converting to an HOPD, for example, and whether or not  
17 there are incentives, there are greater incentives in  
18 addition to everything going on in the market for 340B  
19 hospitals, either to welcome a physician practice that is  
20 wishing to be acquired or to actually seek them out and  
21 whether 340B status is a factor in that.

22 MS. SUZUKI: So I think, in general, it seems

1 like there were expansions, like purchase of physician  
2 practices by both 340B and non-340B entities during this  
3 period. I think our study was addressing a narrow  
4 question, but in looking at the data, we did find both  
5 expansions and not necessarily that 340B dominated the  
6 answer.

7 DR. CROSSON: Okay. Seeing no further questions,  
8 we'll move on to the discussion period. If you look on the  
9 slide up there, the request from the staff is to provide  
10 any further guidance for the formulation of this report,  
11 which is due in March. We had some already in the  
12 discussion period in the prior presentation last month --  
13 or was it November? I can't remember. November. Any  
14 further input?

15 Larry?

16 DR. CASALINO: Yeah, just to be clear, so, I  
17 mean, we've had some discussion, I think, and Kathy was  
18 trying to get at this, about whether 340B increases  
19 hospital employment of oncologists, and I think it's  
20 generally thought that it does. Is it out of scope to just  
21 note, in the report, that 340B can increase costs to  
22 Medicare in more than one way. One way would be what



1 you've studied, and I think what Kathy was getting at, and  
2 Pat, is another way would be if it's increased employment  
3 of oncologists but then, you know, with facility fees  
4 again, that could be rather an actually large increase in  
5 cost to Medicare.

6           But I don't know. I don't think you have the  
7 data for that, so it would be just a note that this could  
8 be the case, and I don't know if that's even in scope. But  
9 it is, just looked at from above, in scope or not, it is  
10 probably an important phenomenon.

11           DR. MATTHEWS: Yeah, we could probably raise that  
12 as a possibility, but we do not have the data to be able to  
13 definitively say one way or the other.

14           DR. CROSSON: Jon.

15           DR. PERLIN: Thanks for a really interesting  
16 report. This may be more 1-1/2 than Round 2 discussion,  
17 because it's someone methodologic. I wonder if one of the  
18 markets of evolution of hospitals using 340B is really  
19 service mix, in the sense that you've identified that 340B  
20 associates with certain particular services. That may be a  
21 marker or a tracer along those lines.

22           The comments are sort of two-fold, is that I

1 think the thread of questions here were really, what is the  
2 relationship between 340B as an instigator of  
3 consolidation. Is there a way to expand access to 340B and  
4 does that motivate consolidation? That's, I think, the  
5 question that was on the table. The discussion on  
6 consolidation in the chapter is somewhat dissociated from  
7 the question of the impact on 340B, and I encourage tying  
8 those together.

9           I also offer, you know, a sort of general  
10 commentary, which is that I was thinking about this  
11 conundrum. We used a fairly small market area for the  
12 providers, the CBSAs, and, you know, the smaller the market  
13 area obviously the more concentrated you'll find the  
14 providers to be. When you get down to a single hospital  
15 it's 100 percent concentrated, as an example.

16           And yesterday we had a discussion about some of  
17 the challenges of consolidation, but we also had a  
18 discussion about the utility of certain integrations. And  
19 as we think about not just one aspect of the Medicare  
20 program but the quality, if you imagine a perfectly non-  
21 consolidated four-hospital town, that each has one quarter  
22 of whatever type of complex patient -- cardiovascular,

1 oncology -- you might say, okay, well, from a market  
2 standpoint it's distributed, but from a quality standpoint  
3 I would tell you that, you know, it's hard to undo volume  
4 outcomes relationship. Would you really expect the care to  
5 be good if you had a number of sub-adequate programs as  
6 opposed to actually a concentrated program?

7           And I wonder, when we think about our discussions  
8 of consolidation, we need not only be thinking about  
9 consolidation at the hospital level but really talking  
10 about some of the high-impact services. And as we think  
11 about some of the high-impact services, I think we need to  
12 think about the dichotomy between, you know, concentration  
13 from a market standpoint but also utility of concentration  
14 from a quality and effectiveness program.

15           If you had four cardiovascular programs, do you  
16 really want four programs that do a handful of heart  
17 transplants every year? Do you really want four programs  
18 that do, you know, advanced oncology? Probably not. You  
19 probably want, you know, facilities that have some lower  
20 level and a center of true excellence that consolidates  
21 expertise.

22           So I think we're losing that thread of, and so

1 those are my two comments on, one, purposefully connecting  
2 the discussion of consolidation with the question of 340.  
3 It stands a little bit on its own. And second, really  
4 asking us to contemplate, you know, the concept of volume  
5 outcomes relationship in terms of sophisticated services.  
6 And I guess a corollary to that is that I wonder if we  
7 don't have to ask ourselves in the next round of  
8 contemplation about how that operates at a service-line  
9 level as opposed to just facility level. Thanks.

10 DR. CROSSON: Thank you, Jon. Warner.

11 MR. THOMAS: Just a couple of comments on the  
12 340B and then on the consolidation. So in the chapter, it  
13 says overall, we found modest evidence of, you know, kind  
14 of associated higher drug spending. But when you just  
15 listen to the discussion and the kind of back and forth,  
16 I'm not sure, you know, if that's necessarily true. I  
17 mean, is it really -- it sounds like it's somewhat  
18 inconclusive.

19 And I guess the other question I would have is,  
20 and I think going back to Larry's comment on the severity  
21 of the patient, it really comes to the stage of the cancer.  
22 I mean, we really don't have insight, that I'm aware of,

1 looking at the rating of what stage of cancer which  
2 significantly drives the type of treatment that a patient  
3 would get and, in many cases, the materiality of the drug  
4 costs. And then you did indicate there's a much higher  
5 propensity of LIS, you know, recipients for many of these  
6 hospitals, normally, although I'm not say that's the case  
7 here, but normally, they're also caught at a later stage of  
8 cancer treatment, just because screening is not at -- and I  
9 don't know if you have that information or not. Do you  
10 have good insight into the stage of cancer, which I think  
11 would provide some insight on the cost side as well.

12           So, I mean, that may be -- if we don't, we may at  
13 least want to make that reference that we don't know that,  
14 and that certainly has a major impact. I do think there is  
15 literature. I look to some of our physician colleagues  
16 here and researchers that normally, in LIS populations, you  
17 do catch cancer at a later stage, which does typically  
18 drive a higher cost structure in treating patients. So I'm  
19 not saying we can make that conclusion, but we may want to  
20 say that that is something that could be happening here as  
21 well.

22           I don't know if any of our physician colleagues

1 want to comment or have any thoughts on that at all.

2 MR. PYENSON: I'm not a physician.

3 DR. CROSSON: Hold on. Thank you for that. Jim  
4 -- let's take Jim and then Bruce.

5 DR. MATTHEWS: So just to address this specific  
6 question, one of the critiques of the prior studies that  
7 have been done looking at the relationship between spending  
8 for Part D cancer drugs at 340B hospitals versus other  
9 hospitals, is that they have not sufficiently controlled  
10 for patient characteristics, including progression of the  
11 disease.

12 MR. THOMAS: Right.

13 DR. MATTHEWS: We have attempted, in this  
14 analysis, to do that by stratifying our analysis by cancer  
15 types. So in that sense, I personally believe it's an  
16 advance beyond some of the other studies that have been  
17 done.

18 However, we do not have the very granular level  
19 on stage of cancer in the data that we are looking at. We  
20 do allude, in the chapter, to, you know, the potential for  
21 unmeasured patient characteristics influencing even the  
22 small differences in spending that we have observed in this

1 study. And to your point, one of the characteristics that  
2 may influence these differences is -- and again, correct me  
3 if I'm wrong -- the patients treated at 340B hospitals tend  
4 to be somewhat younger and may be candidates for more  
5 aggressive interventions, you know, wherever the  
6 progression of their disease is.

7 MR. THOMAS: Yeah, and I think obviously breaking  
8 it down by type of cancer helps tremendously, because  
9 that's, you know, a very different situation, but also  
10 stage within those types of cancers has a big differential  
11 as well. So I just wanted to make a comment.

12 DR. CASALINO: There is a database that can be  
13 used to look at that. And so the SEER-Medicare data does  
14 give you the stage of cancer.

15 MR. THOMAS: Yeah.

16 DR. CASALINO: And I think people who want to  
17 criticize the work will probably ask, you know, about why  
18 didn't you use SEER-Medicare data. It may be that the  
19 sample size wouldn't have been big enough for you. So  
20 that's one question.

21 And just to comment on what Jim just said, I do  
22 think it's very likely that the sickest patients, either

1 initially or when they get really sick, are more likely to  
2 be treated at academic medical centers, and it really is  
3 hard to adjust for that, even if you have stage, frankly.  
4 Although stage would, as Warner is saying, I think, make a  
5 -- it would make -- it would be a more -- it would be more  
6 immune to criticism, I think, if it could be done,  
7 including that.

8 MR. THOMAS: So one's going to --

9 DR. CROSSON: Hold on. One second. Warner,  
10 before you go on, did you want to -- Bruce, did you want to  
11 make a comment on this?

12 MR. PYENSON: Well, just about the costs of, for  
13 example, in lung cancer, early stage, is typically not  
14 treated with chemotherapy today. It's just surgery. Late-  
15 stage patients die very quickly, where most patients are  
16 identified. But there's huge shifts in therapy occurring  
17 today with the immuno-oncology that's probably not too much  
18 reflected in any of the data here. So it's become very  
19 different than it used to be, over time.

20 MR. THOMAS: Okay.

21 DR. CROSSON: You are getting very close to an  
22 honorary MD degree.



1 [Laughter.]

2 DR. CROSSON: And I think that was --

3 MR. PYENSON: I take it all back.

4 [Laughter.]

5 MS. SUZUKI: So I just wanted to respond to some  
6 of the comments about severity. So it's true that our  
7 hospital-level descriptive analysis is not adjusted for  
8 some of the differences in hospitals' patient  
9 characteristics that we talked about, but for the MSA  
10 analysis, the way to think about it is it's an average  
11 across all patients in the MSA. And what we were trying to  
12 measure is controlling for, you know, sort of different  
13 characteristics in the MSA. If the market share for 340B  
14 increased, does that increase the average spending in that  
15 MSA?

16 So I don't think we're as concerned about this  
17 selection issue that you were highlighting. I think our  
18 measure is purely, is the share of 340B driving any  
19 spending increase for cancer drug spending.

20 MR. THOMAS: In total. In total for that area.

21 MS. SUZUKI: Right, and it's a per-month  
22 estimate, but yes. So on average it seems like the share

1 does affect spending for two of the five cancer types.

2 MR. THOMAS: Okay.

3 DR. CROSSON: Warner, are you proceeding?

4 MR. THOMAS: Yeah. Just one other comment, and  
5 obviously today's presentation was a lot more around the  
6 340B conversation. Obviously, the chapter also covers  
7 consolidation, and I just think going to Jonathan's point,  
8 I mean, there has been information added around other -- I  
9 was just looking for the area -- other consolidation that  
10 has occurred.

11 I do think, especially in, you know, insurers  
12 being in the physician world and that sort of thing, I'm  
13 not sure we capture the materiality of it. You know, it  
14 mentions that United Healthcare and Optum, you know,  
15 employs physicians, but they -- at least in their most  
16 recent counts they employed 47,000 physicians, the largest  
17 employer of physicians in the country, and I'm not sure we  
18 capture that materiality, which I think would be important.

19 So, because it kind of seems like it's just kind  
20 of a trend that's just beginning, and actually I think it's  
21 maturing pretty significantly. So I think we could  
22 probably beef up references to those components in the

1 chapter as well.

2 DR. CROSSON: thank you. David.

3 DR. GRABOWSKI: I was just going to make a brief  
4 comment, kind of piggybacking on Jon's, about connecting  
5 some more of the dots here. I felt like -- and this is  
6 more to the provider consolidation part of the chapter than  
7 the 340B -- I felt like the chapter was very good at sort  
8 of getting at the direct effects on Medicare payment, but I  
9 also feel like -- and we've been going through this  
10 exercise at this meeting and the last meeting with the  
11 payment updates -- there's also indirect effects here. And  
12 we live in a world where Medicare pays in a multi-payer  
13 environment, and so as costs are rising, how do we think  
14 about Medicare margins and non-Medicare margins?

15 And I just want to, maybe in the chapter, think  
16 about that interplay. There's obviously direct effects on  
17 Medicare payments but then there's indirect effects in a  
18 world where kind of a rising tide might float all boats.  
19 Thanks.

20 DR. CROSSON: Thank you, David. Paul?

21 DR. PAUL GINSBURG: Yeah, I was going to -- the  
22 issue came up about the effect on physician recruitment

1 that 340B stimulates. And, you know, when I saw the  
2 request for the study my initial reaction was, hey, you  
3 asking the wrong question. Isn't the effect of 340B on  
4 making it more profitable for hospitals to employ more  
5 oncologists, say, the really important thing? I know we  
6 haven't done a study, but I really think that it's  
7 important to mention that there's this possibility, if only  
8 sketching at the logical case, as to why that might be.  
9 And particularly if there's any other literature on that  
10 specific question we could add that in, because otherwise  
11 it just seems strange answering the specific question on  
12 volume of drugs in a vacuum.

13 DR. CROSSON: Thank you, Paul. Kathy.

14 MS. BUTO: Paul was making very much the point I  
15 was going to make, which is I assume underneath the  
16 question that we were asked was a question of is there an  
17 impact on higher costs to the Medicare program? And it  
18 focused on drugs, but I think we know that there are higher  
19 costs to the Medicare program associated with what is sort  
20 of a payment distortion that's drawing certain --  
21 stimulating certain behavior, which I agree with Jon that  
22 some of it is actually very healthy, and I think we'd want

1 more ability to create centers of excellence for oncology  
2 care.

3           On the other hand, I think this is beyond that  
4 because of the attendant costs that go with it in the  
5 outpatient department. So it's hard to pick out a real  
6 increase in drug costs, even as you've done it, but I think  
7 the costs are really much broader to the program. And so  
8 at least to mention that I think would be important as we  
9 complete this chapter.

10           DR. CROSSON: Okay. Thank you. These are very  
11 good comments, and Kim and Nancy and Shinobu, we look  
12 forward to seeing your final report. Thank you so much.

13           We will proceed on to the second session of the  
14 day.

15           [Pause.]

16           DR. CROSSON: Okay. Our final presentation for  
17 today is going to be part of our continuing work on  
18 improvement of the accountable care organization model, and  
19 we're going to be focusing today on the issue of  
20 beneficiary assignment. So David, Luis, and Jeff are here,  
21 and, David, you're going to begin, I guess.

22           MR. GLASS: Yeah, thanks, Jay. Good morning.

1 Today we're going to talk about two issues concerned with  
2 beneficiary assignment to ACOs. I will provide a brief  
3 background, and then Luis will present two concerns about  
4 assignment which lead to your discussion.

5           As you know, ACOs are collections of providers  
6 willing to take accountability for the spending and quality  
7 of care for an assigned patient population.

8           Actual spending is compared to a benchmark. If  
9 spending is under the benchmark, the difference or savings  
10 is shared between Medicare and the ACO. If spending is  
11 over the benchmark, there are two cases. If the ACO model  
12 is one-sided, then the difference between spending and the  
13 benchmark or loss is absorbed by the program. If the ACO  
14 model is shared risk, also known as "two-sided risk," the  
15 ACO may have to pay CMS for some of the difference.

16           Today we are going to concentrate on the Medicare  
17 Shared Savings Program, or MSSP, which is by far the  
18 largest ACO program in Medicare and the only one set up in  
19 statute. The others are demonstrations under CMMI.

20           In 2019, there were 518 ACOs in MSSP, which was  
21 30 fewer than in 2018, but the number of beneficiaries was  
22 at a new high of 10.9 million.

1           New rules went into effect in 2019. Two new  
2 tracks replaced the old track 1, 1+, 2 and 3.

3           There's something called "BASIC," which has five  
4 different levels that range from one-sided the first year  
5 to two-sided by the fifth year.

6           ACOs have to move up the scale in BASIC each  
7 year, so the idea is to move faster and with more certainty  
8 to two-sided risk.

9           However, in 2019 most were still in the one-  
10 sided model, and that's still true in 2020. About two-  
11 thirds are in one-sided.

12           As I just mentioned, ACO performance is computed  
13 relative to the benchmark that CMS sets for the ACO;  
14 therefore, how the benchmark is set is very important to  
15 the individual ACOs. However, to understand if an ACO  
16 model as a whole, such as MSSP, is saving money for  
17 Medicare, a different metric is needed.

18           To understand if an ACO model as a whole is  
19 saving money for Medicare, you have to look at the  
20 counterfactual -- that is, what spending would have been in  
21 the absence of the ACO model.

22           Relative to a counterfactual, we found slower

1 spending growth for beneficiaries assigned to an ACO in  
2 2013, about 1 or 2 percent through 2016. That estimate  
3 does not include shared savings payments. If they had been  
4 included, savings would have been less.

5           We also found that beneficiaries who were  
6 continuously assigned to an ACO had lower spending than  
7 those who were newly assigned to the ACO or lost assignment  
8 to an ACO. And we also found that a health event such as a  
9 hospitalization could lead to a switch in a beneficiary's  
10 ACO assignment and to higher spending.

11           So over all ACO models, studies tend to estimate  
12 1 to 2 percent savings, or about 1 percent after shared  
13 savings payments, and results depend on the program and the  
14 specific evaluation. So we included results from the PGP,  
15 Pioneer, and NextGen demonstrations, as well as other  
16 evaluations of MSSP in your mailing material. The point is  
17 savings are relatively small, and if shared savings  
18 payments are unwarranted, they could shift an ACO program  
19 from small savings to program losses.

20           Luis will now explain two of our concerns about  
21 current rules in the MSSP and their potential for  
22 unwarranted shared savings.



1           MR. SERNA: This morning we will address two  
2 concerns we have with current MSSP assignment rules, and we  
3 will provide potential options for addressing those  
4 concerns. I will now go over the first of these concerns:  
5 identifying ACOs through taxpayer identification numbers,  
6 TINs, to create benchmarks and assign beneficiaries.

7           It is important to understand that this  
8 discussion strictly addresses how ACOs are defined for  
9 purposes of calculating the beneficiaries assigned to ACOs  
10 to create benchmarks.

11           Before discussing our concerns with TIN level  
12 assignment, it is important to understand how ACOs are  
13 defined. First, let's review some terminology for  
14 identifying providers.

15           Each clinician has one national provider  
16 identified, or NPI. An NPI can bill under one or more  
17 taxpayer identify numbers, or TINs. A TIN can range from a  
18 solo practitioner to hundreds of clinicians within an  
19 integrated delivery system.

20           MSSP identifies participants in an ACO as a  
21 collection of one or more TINs which are used to construct  
22 benchmarks and determine beneficiary assignment.

1 Beneficiaries are assigned to ACOs based on a TIN under  
2 which their claims are billed. However, TINs were not  
3 designed for that purpose. A concern of inaccurate  
4 benchmarks arises when a clinician shifts which TIN she  
5 bills under or if the clinician starts to bill under  
6 multiple TINs.

7           When this occurs, the changes in how NPIs bill  
8 through TINs are not reflected in ACOs' benchmarks. In  
9 MSSP, TINs are used to calculate an ACO's benchmark and  
10 performance spending. Benchmarks represent the spending  
11 for beneficiaries who would have historically been assigned  
12 to the ACO's current list of TINs in the base years.  
13 Assignment is obtained by having the plurality of primary  
14 care visits to the ACO's TINs.

15           An ACO's shared savings is determined by  
16 measuring its performance year spending against its  
17 benchmark. Performance year spending is calculated via the  
18 beneficiaries who are assigned to the ACO's current list of  
19 TINs in the performance year. Changes that an ACO makes to  
20 its list of TINs takes effect in the subsequent year, when  
21 CMS annually recalculates an ACO's benchmark based on its  
22 updated list of TINs. CMS does not recalculate benchmarks

1 based on changes in the NPI's billing under the TINs.

2           However, the use of TINs to identify an ACO's  
3 clinicians weakens the utility of historical assignment and  
4 benchmarks, potentially creating unwarranted shared  
5 savings.

6           When individual clinicians leave or join a TIN,  
7 the beneficiaries historically assigned to that TIN do not  
8 change, and the ACO's benchmark is also unchanged.

9           The figure in this slide illustrates how changes  
10 in clinicians who make up a TIN could lead to unwarranted  
11 shared savings.

12           In the benchmark year, the TIN is comprised of  
13 Clinician A and Clinician B. If Clinician A's  
14 beneficiaries are high cost and Clinician A is removed from  
15 beneficiary assignment for the performance year, these  
16 high-cost beneficiaries remain in the ACO's benchmark.

17           Further, if the ACO adds Clinician C, who has  
18 historically low spending, to its TIN, the ACO's benchmark  
19 would not reflect the low cost of this provider's  
20 beneficiaries, but performance year spending would. The  
21 mismatch between the benchmark and performance year  
22 clinicians raises potential concerns about the accuracy of

1 shared savings.

2           One alternative to TIN-level benchmarks is to  
3 identify ACO clinicians based on combinations of TIN and  
4 NPI. This method is used in the NextGeneration ACO  
5 demonstration. This method solves the problem of  
6 benchmarks not changing when clinicians are removed from  
7 TINs.

8           However, identifying ACO clinicians through TIN  
9 and NPI combinations have some similar concerns to using  
10 TIN-level benchmarks. Benchmarks are not adjusted for NPIs  
11 added to TINs. Moreover, NPIs may selectively bill to TINs  
12 outside the ACO without a corresponding change to  
13 benchmarks. One ACO interviewed in a 2019 RAND study  
14 created a separate TIN for clinicians that  
15 disproportionately saw high-cost patients.

16           Rather than basing historical benchmarks off of  
17 TIN or a combination of TIN and NPI, NPI-level benchmarks  
18 would most accurately capture the ACO's historical  
19 spending.

20           Any changes in an ACO's performance year  
21 clinicians would correspond with changes in the clinicians  
22 used for historical benchmarks.

1           One potential issue to using NPI-level benchmarks  
2 is that historical benchmarks may be more likely to capture  
3 the historical claims of clinicians who joined an ACO after  
4 having moved from a different market that was outside the  
5 ACO's service area. Consequently, the claims outside of  
6 the ACO's service area would have to be removed from  
7 benchmarks.

8           Use of NPI-level benchmarks would also mean that  
9 clinicians would only be able to participate in one ACO.  
10 Consequently, clinicians with a wide range of TIN billing  
11 arrangements may be less likely to participate in an ACO.  
12 Under any of these arrangements, clinicians would still see  
13 and bill for any Medicare fee-for-service beneficiary.  
14 This change would just affect which claims were counted for  
15 ACO performance spending.

16           It's important to understand that redefining ACOs  
17 on the basis of clinicians' NPI would not require any  
18 changes to the structure of the ACO, its clinicians, or the  
19 specialists clinicians may prefer for beneficiaries. Here  
20 we illustrate an example of the current definition of an  
21 MSSP ACO, which is a collection of TIN 1 and TIN 2.

22           NPI A only bills under TIN 1. NPI B historically

1 only billed under TIN 2. However, NPI B subsequently  
2 begins billing under TIN 3, which is outside the ACO. If  
3 MSSP ACOs were redefined on the basis of NPIs, the ACO and  
4 its affiliated clinicians would have the exact same  
5 structure and billing arrangements. The only difference is  
6 that rather than the ACO being defined as a collection of  
7 TINs, the ACO is now defined as a collection of clinician  
8 NPIs.

9           To summarize the options for defining ACOs: For  
10 the option of defining ACOs as a collection of TINs,  
11 inaccuracies in the benchmark occur when a clinician is  
12 removed from a TIN, added to a TIN, or selectively bills to  
13 a TIN outside the ACO.

14           This potentially leads to unwarranted shared  
15 savings if an ACO removes high-cost clinicians or adds low-  
16 cost clinicians to a TIN.

17           For the option of defining ACOs as a collection  
18 of TIN and NPI combinations, inaccuracies in the benchmark  
19 also occur when a clinician is added to a TIN or  
20 selectively bills to a different TIN. This potentially  
21 leads to unwarranted shared savings if an ACO adds low-cost  
22 clinicians to a TIN or selectively removes high-cost

1 beneficiaries through use of an additional TIN.

2           The option of defining ACOs as a collection of  
3 NPIs largely mitigates the potential benchmark inaccuracies  
4 listed above, but historical claims from outside the ACO's  
5 service area would have to be excluded, and physicians  
6 would only be in one ACO.

7           The last concern with MSSP assignment we will  
8 discuss today is retrospective beneficiary assignment.  
9 Under the latest MSSP rules, ACOs can annually choose  
10 retrospective or prospective assignment. In retrospective  
11 assignment, beneficiaries are assigned based on primary  
12 care visits during the performance year. In prospective  
13 assignment, beneficiaries are assigned during the prior  
14 year. In our October 2018 comment letter, we highlighted  
15 concerns with allowing annual choice of retrospective or  
16 prospective assignment and the negative incentives it could  
17 introduce. Next, we summarize the advantages and  
18 disadvantages of prospective and retrospective assignment.

19           The main advantage of retrospective assignment is  
20 that the ACO is never responsible for the spending of  
21 beneficiaries its clinicians did not see during the  
22 performance year. However, it opens the door to potential

1 favorable selection.

2           In contrast, prospective assignment mitigates the  
3 potential for favorable selection and provides more  
4 certainty.

5           In prospective assignment, ACOs are never  
6 responsible for beneficiaries their clinicians have not  
7 previously seen, creating more certainty in assignment at  
8 the beginning of the year.

9           Under prospective assignment, ACOs are also more  
10 accountable for decedents, and prospective assignment  
11 mitigates unwarranted shared savings if ACOs target low-  
12 spending patients at the end of the year (such as through  
13 wellness visits).

14           In our June 2019 report, we found that  
15 retrospective assignment may exacerbate spending  
16 differences from assignment changes. These assignment  
17 changes often corresponded with changes in health care use.

18           Newly assigned beneficiaries (or joiners) and  
19 beneficiaries who lost assignment (or leavers) had higher  
20 average spending relative to beneficiaries who remained  
21 assigned to the ACO (or stayers). This is concerning  
22 because it may incent ACOs toward patient selection.



1           This brings us to the question of whether  
2 spending differences between ACO stayers, leavers, and  
3 joiners are alleviated under prospective assignment.

4           To answer this question, we simulated MSSP  
5 prospective assignment by using the prospective list of  
6 assigned beneficiaries CMS sends to all MSSP ACOs prior to  
7 the start of the performance year. We compared the 2017  
8 spending of the ACOs that used retrospective assignments  
9 with the spending for those ACOs under a simulated  
10 prospective assignment.

11           We found that prospective assignment reduced the  
12 differences in spending between assignment stayers,  
13 leavers, and joiners. This increased parity under  
14 prospective assignment reduces the potential of rewarding  
15 ACOs for patient selection. The increased parity occurs  
16 because spending is determined a year after assignment and  
17 is, therefore, less tied to changes in health status during  
18 the year.

19           The average spending for stayers increased by  
20 about \$900. This is partially because low-spending  
21 beneficiaries who were only assigned through an annual  
22 wellness visit had almost no spending under retrospective

1 assignment but now have some spending in the year following  
2 the wellness visit. Also, decedents with a prior E&M visit  
3 during the year are more likely to be assigned  
4 prospectively rather than retrospectively.

5           Under prospective assignment, the average  
6 spending for leavers and joiners decreased by more than  
7 \$1,000, respectively. This is because sharp changes in  
8 health care use caused spending that was larger during the  
9 year of assignment compared with the following year. Keep  
10 in mind benchmarks would be calculated on a prospective  
11 basis as well, so we do not anticipate the difference  
12 between spending and benchmarks would change appreciably.

13           Overall, prospective assignment reduces potential  
14 rewards from patient selection.

15           That brings us to our questions for your  
16 discussion.

17           Should prospective assignment be mandatory for  
18 MSSP? For some time, we have been discussing the potential  
19 improvements that prospective assignment would have on  
20 MSSP. If the Commission is comfortable, we could come back  
21 with a recommendation in the spring.

22           Should MSSP use NPI instead of TINs to identify

1 clinicians in ACOs? Is there additional information the  
2 Commission would like on this topic?

3 Are there other policy ideas related to ACO  
4 assignment that the Commission would like to discuss?

5 We look forward to the discussion on these  
6 points, and now we turn it back to Jay.

7 DR. PAUL GINSBURG: It's Paul now.

8 MR. SERNA: Who's not here.

9 DR. PAUL GINSBURG: We're open for clarifying  
10 questions. Brian, Jonathan, Larry. I'll come back for  
11 more.

12 DR. GRABOWSKI: And David.

13 DR. PAUL GINSBURG: And David.

14 Anyone else?

15 [No response.]

16 DR. PAUL GINSBURG: Okay. Go ahead, Brian.

17 DR. DeBUSK: First of all, thank you for an  
18 excellent chapter. It was a really, really great read.

19 If we could go to Chart 13, please. When you  
20 talk about the physicians for the assignment, basically a  
21 physician has to be assigned to a single ACO now. I mean,  
22 obviously, with this new method, you can't go backward.

1           I had two questions. First of all, we already  
2 wrestle with specialists' participation in ACOs. The  
3 question always comes up: What about the specialists?

4           When I think of primary care, it's not an issue,  
5 but could you speak to specialist engagement and what this  
6 could do and what percentage of physicians in ACOs are  
7 specialists now and how many could be affected? So that's  
8 my first question is sort of this disproportionate impact  
9 of specialists versus primary care physicians under this  
10 new proposed rule.

11           Then the other question is, considering the  
12 subject that we just took up, could you speak to any effect  
13 this could have on consolidation? Could this inadvertently  
14 force physicians to choose sides, and would that have a  
15 consolidating effect?

16           MR. GLASS: Well, I think at one point, we looked  
17 at the percentage, percentages of specialists and primary  
18 care physicians, and they were about the same in ACOs as  
19 they are out in the rest of the world -- the rest of the  
20 United States.

21           And a specialist could still be in an ACO, but it  
22 could only be a participant in one ACO. He can still

1 perform surgery, say, on any patient that wanted to show up  
2 there, regardless of the patient's assignment.

3 DR. DeBUSK: Well, for example, an orthopedic  
4 surgeon in a given town, though, let's say there are two  
5 ACO models within this MSA.

6 MR. GLASS: Right.

7 DR. DeBUSK: You'd basically have to choose one  
8 or the other for your ACO participation.

9 MR. GLASS: That's right.

10 DR. DeBUSK: But not necessarily for your  
11 privileges. I understand that.

12 MR. GLASS: Correct. And that surgeon -- I mean,  
13 patients would probably not be assigned through that  
14 surgeon, anyway, because they're assigned nonprimary care  
15 visits.

16 So the specialist participation in an ACO may not  
17 contribute a tremendous amount to the assignment of the  
18 patients to the ACO. Whether the surgeon gets shared  
19 savings from an ACO, another question. That's up to the  
20 ACO to decide how to split things up. So not being in the  
21 ACO may not make much material difference to the surgeon,  
22 anyway.

1 DR. STENSLAND: This is just for assignment. If  
2 you're a surgeon and we have two ACOs, you could say for  
3 ACO 1, I'm in this ACO as its list of providers, and I will  
4 have my patients assigned to that ACO if they never see a  
5 primary care doctor during the year and they only see me.  
6 That's not a big deal.

7 In the ACO No. 2, you could still be a preferred  
8 provider, and in certain models, you could agree to be paid  
9 by even that ACO. There are some models where the ACO gets  
10 the money, and then they pay you. And you can create your  
11 own compensation arrangements with that ACO.

12 So working with two different ACOs is okay.  
13 Having financial arrangements with two different ACOs is  
14 okay. It is only assignment goes through the one ACO, and  
15 for you, you're probably not going to have that many  
16 patients that never saw a primary care doctor.

17 DR. DeBUSK: SO you could do an affiliation  
18 agreement with only one ACO, but you could still  
19 participate in financial arrangements through multiple ACOs  
20 just by being on the provider list.

21 DR. STENSLAND: Yeah.

22 DR. DeBUSK: Got it. Thank you.

1 DR. PAUL GINSBURG: Yeah. Actually, a follow-up.  
2 Of the physicians who were assigned to -- where  
3 beneficiaries are -- that lead to beneficiary assignments  
4 to an ACO, such as primary care and specialists where there  
5 is no primary care physician and they're perceived, what  
6 percentage of those are specialist?

7 MR. SERNA: So it's roughly about 10 percent of  
8 beneficiaries are assigned through specialists who do not  
9 have a primary care visit with a PCP.

10 DR. PAUL GINSBURG: Okay.

11 DR. SAFRAN: And on that point, do you know of  
12 that 10 percent, how much are medical versus surgical  
13 specialists?

14 MR. SERNA: I do not, but not all specialists are  
15 eligible for beneficiary assignment. I believe there's a  
16 set of about six or seven types of specialists --  
17 nephrologists, endocrinologists, hematologists, and  
18 cardiologists.

19 DR. SAFRAN: So to the point that, Jeff, you were  
20 just making, I think that a patient who only saw a surgeon  
21 in the year wouldn't get assigned at all; is that correct?

22 DR. STENSLAND: That's a good point.

1 DR. PAUL GINSBURG: Good.

2 Jonathan?

3 DR. JAFFERY: Yeah. Thank you.

4 So this is a really fun chapter, which I think  
5 solidifies my position as a geek pretty solidly.

6 [Laughter.]

7 DR. JAFFERY: Honestly, so now we have stayers,  
8 leavers, joiners, and switchers. That's what we've got.  
9 That's what we're working with.

10 I think just to build on the conversation that  
11 was just happening here, first of all, one clarifying  
12 point, because, Brian, you talked about affiliation  
13 agreements, and there actually is this category in some  
14 newer models, as Jeff was saying, about preferred  
15 providers. You can be a participant, which would be if you  
16 were in a category where your patients could be attributed  
17 to the ACO as a participant. Those patients would go to  
18 one ACO, but you could be a preferred provider for multiple  
19 ones.

20 Some of the questions were getting at what I'm  
21 thinking about in terms of how many people are attributed,  
22 what percentage, by specialist. Do we have information



1 about how many people, how many providers are in multiple  
2 ACOs? Is there any breakdown by primary care and  
3 specialist after that?

4 MR. SERNA: We could definitely look into that.  
5 We've only looked at it for PCPs, and, of course, most PCPs  
6 are only assigned to one ACO. Actually, about 5 percent of  
7 PCPs were assigned to multiple ACOs. Yeah.

8 DR. CROSSON: Larry?

9 DR. CASALINO: For some reason, I realize there's  
10 a limited number of combinations, but I'm finding it still  
11 difficult to work through.

12 One of the problems with TIN-level assignment is,  
13 as you said, that strategic TINs could be set up, for  
14 example, to really game the system. With NPI-level  
15 assignment, I think in the example you showed, the  
16 particular physician who was in the ACO, if they move --  
17 could you show that slide again? I'm not sure which one it  
18 is, the first one you showed. Yeah.

19 So if NPI B moves to TIN 3, that could be  
20 strategic, as you guys mentioned, for gaming the system,  
21 but it also could be -- and this probably would be more  
22 common, I would think -- the physician could actually

1 switch to a different medical group that has a different  
2 TIN and happens not to be part of the ACO, right? I mean,  
3 that would be not an unusual event, I wouldn't think.

4           So, in that case, when I read this, I thought,  
5 "Oh, yeah. NPI assignment is the way to go, but I just  
6 want to see if I understand correctly. If a physician  
7 switches, an NPI switches to a medical group that's not  
8 part of the ACO, with NPI-level assignment, the patients  
9 would still be assigned to the ACO, that NPI's patients.  
10 Is that correct?

11           MR. GLASS: No. Because the NPI would probably  
12 no longer be a participant in the ACO. If his medical  
13 group switched out of the ACO completely or he switched to  
14 a medical group that was not in the ACO, then his NPI would  
15 not be a participant in that ACO. So it wouldn't be this  
16 picture. It would be NPI B moving out of the ACO box.

17           DR. CASALINO: But how would you know that the  
18 NPI had moved out of the ACO?

19           MR. GLASS: Because the ACO sends to CMS each  
20 year a list of participants, and at the end, if you were to  
21 use NPI-level participation, the ACO would send CMS a list  
22 of NPIs that who are participants in the ACO.

1 DR. CASALINO: And if the NPI switches medical  
2 groups to outside the ACO in February or something like  
3 that, are these lists updated?

4 MR. GLASS: Yeah. The lists are, I believe,  
5 updated quarterly?

6 MR. SERNA: Yeah. So the lists are updated  
7 quarterly, but the changes wouldn't take into effect until  
8 the subsequent performance year.

9 DR. CASALINO: Okay.

10 MR. SERNA: So, in this case, if the change was  
11 made in February, those patients for that physician would  
12 still be assignable to that ACO until the next year.

13 DR. CASALINO: Okay. So it could be a  
14 disadvantage. I'm not trying to make an argument here, but  
15 I'm just still trying to understand.

16 NPIs are probably more likely to move to a  
17 different medical group than medical groups are to move  
18 outside an ACO, I think, in a year.

19 MR. GLASS: Well, that's a question.

20 DR. CASALINO: Yeah. Okay.

21 MR. GLASS: Also, as you say, one could  
22 strategically move NPIs or TINs in and out.

1 DR. CASALINO: Yeah.

2 DR. JAFFERY: On this point. So that this issue  
3 of somebody leaves in February, if they were assigned by an  
4 NPI-TIN, you'd still have the same issue, right? I mean,  
5 they're still part of the part.

6 MR. SERNA: Yes. It's the same issue.

7 DR. JAFFERY: Okay.

8 DR. CASALINO: It's a little different TIN  
9 assignment if TINs are less likely --

10 DR. CROSSON: Mic, Larry?

11 DR. CASALINO: Oh, sorry.

12 DR. JAFFERY: But if a lot of the current models  
13 have moved to NPI-TIN combinations, and in that situation,  
14 I think you'd have the same.

15 DR. CROSSON: Okay. Dana?

16 DR. SAFRAN: Yeah. Thanks.

17 I originally didn't have a question on this  
18 topic, but I'll just raise one. Have you thought about the  
19 impact on this issue of physicians switching out or in this  
20 picture, an ACO deciding to strategically move an NPI to a  
21 TIN that's not part of their list, if the list was based on  
22 TIN, not on NPI? That would then deny that physician their

1 APM participation bonus, which is a significant 5 percent,  
2 right?

3           So I'm just curious whether you've considered  
4 that piece of things in terms of how this dynamic could  
5 work.

6           MR. SERNA: Yeah. So for purposes of being part  
7 of the APM, CMS could collect the same information. So,  
8 administratively, things don't have to change drastically.  
9 So they could still collect a set of TINs and just require  
10 that all the NPIs under that TIN are participants, as they  
11 do now, but the assignment of benchmarks would be  
12 calculated at the NPI level. So everything would remain  
13 the same, and the physician still is part of the ACO.

14           DR. SAFRAN: Okay, okay.

15           MR. SERNA: In this instance, we would just have  
16 to make sure that the physician is only part of one ACO for  
17 purposes of measuring assignment.

18           DR. SAFRAN: I see. Okay.

19           So my original question, which I'll turn to now,  
20 had to do with prospective versus retrospective. There's  
21 actually two questions here.

22           One is, in the work at Blue Cross Mass, we use

1 what we called "concurrent attribution," and I'm curious.  
2 Is that something that you looked at? Because I haven't  
3 seen it talked about.

4 MR. SERNA: So retrospective assignment is  
5 essentially a concurrent assignment. The ACOs are sent  
6 lists that are updated quarterly, and then there's the  
7 final list at the end of the performance year that is  
8 actual assigned beneficiaries for which the performance  
9 spending will be calculated.

10 DR. SAFRAN: Okay. So I had a hunch there was  
11 just a nomenclature thing going on there, because  
12 oftentimes people talk about retrospective as if it doesn't  
13 make sense. You're supposed to manage a population. How  
14 can you manage a population if you don't know who's in your  
15 population? But that's not actually how it works. You are  
16 getting lists all throughout the year, and it's only  
17 retrospective in the sense that it gets settled at the end  
18 of the year in terms of over the year who manifests as  
19 actually being your patient.

20 MR. SERNA: Yeah, that's correct.

21 DR. SAFRAN: I think that should be made clearer.  
22 And "retrospective" is just a very misleading

1 word when it comes to like an accountable model. Probably,  
2 80 percent of the people in this room, maybe even around  
3 this table, think that that means you don't know who your  
4 population is until December 31st. So I would just suggest  
5 that we clarify the language.

6           That's probably around two comments.

7           A question. As you thought about this issue of  
8 movers and switches and all of that, I guess what I read in  
9 what you're saying is a kind wanting to neutralize the  
10 effect that you see in the data, which we've seen for a  
11 long time. Typically, a health event precipitates somebody  
12 changing providers, whether it's an ACO or not, and so the  
13 one they go to is picking up a case where something is  
14 wrong and some care is needed.

15           So I guess I'm just curious about the thinking  
16 behind that and this interest in sort of neutralizing  
17 because it does strike me that we would want those who are  
18 accepting the case to feel accountable for that case, that  
19 cases now come to them and the patient has a health problem  
20 that needs to be managed.

21           So I just want to understand the thinking better  
22 in the work that you sort of summarize on Slide 17, but

1 that was a big part of that segment of the chapter.

2 Thanks.

3 MR. GLASS: Yeah. I mean, part of the idea is  
4 that we want to remove the possibility for gaming the  
5 thing, basically. In other words, you don't want to set up  
6 a system where it's really good for the ACO to do a  
7 wellness visit at the end of the year when they know the  
8 person has no claims for that year and ensure that person's  
9 assignment to the ACO. It's the susceptibility to  
10 selection that makes us want to kind of even out those  
11 numbers.

12 DR. CROSSON: David, on this point?

13 DR. GRABOWSKI: Yeah. What does the set of  
14 beneficiary characteristics on spending look like year to  
15 year? I think that would tell me whether there's selection  
16 or not, not the statistics -- I'm sorry -- on Slide 17 on  
17 sort of the stayers, the leavers, and the joiners. I think  
18 this is where Dana was going. I don't know that those are  
19 very informative. I think it's been relatively balanced  
20 year to year.

21 I realize this is more Round 2 than Round 1, but  
22 what is the sort of pool of --



1 MR. GLASS: Oh, you're saying what's the balance  
2 between joiners and leavers --

3 DR. GRABOWSKI: No. Overall spending in the  
4 group look like year to year, I think that's pretty  
5 balanced, whether you use prospective or retrospective. I  
6 don't think selection has been a big sort of issue here.

7 MR. GLASS: Well, we don't know that it has been  
8 in the past, but we'd like to not sent up incentives for it  
9 in the future. And I think we gave an example in your  
10 mailing materials if one ACO were to appear at that.  
11 Perhaps there was some strategic things going on.

12 DR. GRABOWSKI: I guess, though, on this idea of  
13 stayers, leavers, and joiners, I don't know what that tells  
14 us. I would want us to sort of pull back from that. I  
15 think there's better metrics. I don't think this tells a  
16 selection. I think we'd want to look at kind of what does  
17 the overall population look like. These could be very  
18 misleading.

19 DR. STENSLAND: One alternative --

20 DR. CROSSON: Wait. Hold on. Sorry. Are you  
21 answering?

22 DR. STENSLAND: I was going to ask David back a

1 question, but one alternative is if you go back to what we  
2 showed before was that individuals who are assigned via a  
3 wellness visit tended to have very low costs in that year  
4 of assignment. In fact, the wellness visit was a good  
5 indicator of how much cost you had earlier in the year, but  
6 it wasn't such a good indicator of how much cost you're  
7 going to have in the future. So we could show that, that  
8 this would clearly be a profitable strategy, if you could  
9 look at your HRR-adjusted costs are low when you're  
10 assigned by a wellness visit.

11 DR. GRABOWSKI: I would want to check overall to  
12 look for selection here. I'm less concerned about these  
13 issues around retrospective or prospective. I would want  
14 to see are there sort of broader kind of selection issues  
15 and are there ways to kind of test for that, and as David  
16 just said, to date we haven't seen that.

17 Now, I think under the new sets of incentives,  
18 we'll probably see more of it.

19 DR. STENSLAND: You probably will.

20 But, yeah, I think this is definitely not saying,  
21 "Oh, let's look at our old results, and we're concerned  
22 that it was selection that was causing them." I don't

1 think that's what we're saying.

2           We're saying are there some vulnerabilities in  
3 the current model where people can start directing their  
4 resources towards selection rather than better patient  
5 management and increase their shared savings, and how could  
6 they do that?

7           DR. CROSSON: Okay. I saw a bunch of hands. Who  
8 wanted to join on this point? Bruce and Jonathan.

9           And then anybody else wanted to get in the queue?  
10 Pat. Okay.

11           Yeah, I have you, Larry.

12           Okay. Bruce and then Jonathan on this point.

13           MR. PYENSON: Yeah, just on the selection issue.  
14 There is an episode that happened a couple of years ago  
15 when CMS decided to remove site of service 31 from the  
16 attribution, from the claims used for attribution. That  
17 was a nursing home site of service. And that led to some  
18 pretty dramatic shifts of people in and out of ACOs. Now  
19 that was an example of inadvertent selection and change and  
20 fluctuation. But I think there's no question that there's  
21 a huge interest by ACOs in evaluating potential additions  
22 or subtractions from their attribution, based on the

1 potential profitability of those individual physicians and  
2 physician groups.

3           So this is very much in the visibility of the ACO  
4 industry, so I think it's definitely a good thing to look  
5 at. The vulnerability has been recognized broadly in the  
6 industry.

7           DR. CROSSON: Thank you, Bruce. Jonathan.

8           DR. JAFFERY: Yeah, thanks. So focusing, I  
9 think, the response to Dana's questions about this in terms  
10 of ways that ACOs might game getting expensive people out,  
11 but then, you know, thinking about this notion of, you  
12 know, should ACOs be accountable for patients even if they  
13 do have higher health needs and new health conditions, the  
14 onset of new health conditions.

15           I guess I've been thinking of it from the other  
16 angle which is if you take in patients that have suddenly  
17 got a new health condition and yet your benchmark is based  
18 on people who didn't have that, a predominance of people,  
19 so that -- I guess can you comment on it from that angle?  
20 To me that's just as an important angle.

21           MR. SERNA: Yeah. So I think that's why we  
22 included the joiners in this analysis, because I think

1 that's what you're taking about is you don't want an ACO's  
2 shared savings to be determined by the balance of its  
3 leavers and joiners, right? I mean, overall you don't see  
4 selection, but it may just so happen that the mix of  
5 clinicians within an ACO means that they get more expensive  
6 patients relative to patients that leave the ACO, right?  
7 So I think this speaks to that being more balance and  
8 shared savings being more accurate.

9 DR. CROSSON: Okay. Larry?

10 DR. CASALINO: Yeah. Going back again to the  
11 question of one of the problems with retrospective  
12 assignment being that the strategic use of wellness visit,  
13 which I think to the extent we continue with retrospective  
14 assignment I think we can anticipate seeing more strategic  
15 use, as, yeah, you'll get to seem like a dumb ACO if you're  
16 not doing that.

17 So, you know, if we step back for a second and  
18 just think about assignment on the basis of a single claim  
19 or a single E&M visit or service in a year, if you actually  
20 think about it, it's not all that plausible that just  
21 because you have a visit with some provider that that  
22 provider is really responsible for you. Now I know there

1 was this debate early on, and I think it's kind of been  
2 mostly forgotten as far as I know.

3           But do you have any information or any thoughts  
4 on what if it took two visits or two E&M services in a year  
5 to be assigned? I guess it might be hard. You'd get a lot  
6 of ties and I guess that could be a problem. But two would  
7 be a lot more credible than one, in terms of assignment,  
8 and might, just to a considerable extent, solve the  
9 wellness visit gaming. Thoughts about that? Has anyone  
10 actually looked at, to your knowledge, or have you guys  
11 looked at what difference it would make if required two  
12 rather than one to assign, two or more?

13           MR. SERNA: So I think part of the issue is that  
14 even for wellness visits, roughly about 40 percent of  
15 wellness visits there's another E&M service alongside the  
16 wellness visit. So would that count as two or would that  
17 count as one? And that kind of gets into what exactly is  
18 one encounter versus two encounters.

19 DR. CROSSON: Another variation of that would be, in  
20 retrospective assignment, excluding the situation where the  
21 only visit during the year was a wellness visit. Similar  
22 idea.

1 David.

2 DR. NAVATHE: For what it's worth, just on this  
3 point, there are definitely commercial attribution  
4 algorithms that use the two visit -- two separate visits as  
5 a form of attribution.

6 DR. SAFRAN: I'll just mention the downside of  
7 that is you start to have smaller percentage of people  
8 attributed.

9 DR. CROSSON: David.

10 DR. GRABOWSKI: Great. I wanted to ask you about  
11 an example you provided in the text of the report on page  
12 15 about an expensive procedure like a knee replacement.  
13 And take me to what happens. So that -- you give the  
14 example, there's this anticipated need for this expensive  
15 procedure, and they lose assignment. What happens to their  
16 baseline spend? Is there any sort of -- that's excluded,  
17 that's not attributed. What happens? Does risk adjustment  
18 at all address this currently or not?

19 DR. STENSLAND: So I didn't have a lot of costs  
20 last year, and you know that, so I have a low risk score.  
21 And you're my physician and I'm coming to you and thinking,  
22 you know, my hip is bothering me. And what you could do is

1 say, "Oh well, I think you really need to see a more  
2 compassionate physician, Jon Perlin, my friend, who  
3 absolutely--"

4 DR. PERLIN: Don't do that.

5 DR. STENSLAND: He is in an integrated medical  
6 system. They have orthopedic surgeons there. Then you'll  
7 have your primary care and your orthopedic surgery all at  
8 the same place. It will be more coordinated. Your medical  
9 records will be shared back and forth.

10 Then me, who this year, you know, or next year,  
11 even under prospective, you know is going to have an  
12 expensive year because you're having a hip replacement, and  
13 you know you're going to have an expensive risk-adjusted  
14 year because your HCC is from the prior year when you  
15 really didn't have too many diagnoses. And that person is  
16 no longer going to be on -- you're not going to be  
17 responsible for their spending anymore. It's going to be  
18 this integrated delivery system that's going to be  
19 responsible for their spending.

20 DR. GRABOWSKI: And one other question I wanted  
21 to ask about was just this issue around TIN splitting.  
22 Maybe put up Slide 12. I was trying to think through the



1 incentives here, and if I -- would I find it easier to kind  
2 of exclude physicians based on their NPIs, and maybe this  
3 is a variation of Larry's question from earlier. But if I  
4 was going through and trying to find the high-cost docs, at  
5 the NPI level, versus the TIN level, with regional  
6 benchmarks, isn't the NPI approach easier to sort of pick  
7 out the kind of problem children in that?

8 DR. STENSLAND: Yeah, so I think that's what I  
9 was trying to allude to earlier. So CMS could still have  
10 the requirement where they collect TINs, and all NPIs under  
11 those TINs have to be assigned to the ACO, I mean, as they  
12 do now. It's just the actual measurement of assignment and  
13 benchmarks is a collection of NPIs rather than the  
14 collection of TINs. So if that was a concern it would be  
15 addressed in that way.

16 DR. GRABOWSKI: Got it. And just as a final  
17 question, you have a term in the report, like -- and I  
18 think you used it even, Luis, during the presentation,  
19 "benchmark accuracy." And I think folks are going to react  
20 to that, because benchmarks can be accurate or inaccurate.  
21 And so just cleaning that up, that, you know, I think  
22 unwarranted shared savings was another way you framed that.

1 But just being careful about that, because these whole  
2 benchmarks are not counterfactuals and that's going to  
3 cause people to react. So just as a comment.

4 DR. CROSSON: Larry, do you have a comment on  
5 David's comment?

6 DR. CASALINO: [Off microphone.]

7 DR. STENSLAND: I was just going to try to clear  
8 up. I don't know if this was clear, but the main point is  
9 to match the people that are in your benchmark to the  
10 people that are in your performance year. And so the  
11 concern is when it's TIN-based you have -- your TINs are  
12 going to measure your base period. And you have, say, one  
13 doctor who has a lot of people that are non-compliant or  
14 cognitively impaired, and they just look expensive relative  
15 to their HCC, and they're in your baseline. You could say,  
16 well, let's have that person bill under another TIN, and  
17 the problem is they start billing it under another TIN,  
18 their high-cost patients are still in your baseline. So  
19 you get them to create your benchmark but you don't have  
20 them for your performance year. And you get this mismatch  
21 of having expensive people in your benchmark and being able  
22 to get them out of there before they hit your performance

1 year, and that's kind of the problem that we're trying to  
2 avoid.

3 DR. CROSSON: Yeah.

4 DR. CASALINO: Is there any evidence that -- I'm  
5 just throwing this off as -- I don't know, maybe it's a  
6 question -- is there any evidence that if physicians behave  
7 in the way that was just postulated, that you would tell a  
8 patient not to be your patient anymore, to improve your  
9 ACO? Certainly physicians respond to financial incentive,  
10 but I think it's important to distinguish things that an  
11 organization can do and things that an individual physician  
12 is likely to do. So wellness visits, you know, I doubt  
13 that the ACOs that are doing that are kind of leaving it up  
14 to the individual physicians. They are probably putting,  
15 systematically, you know, inviting patients in for wellness  
16 visits, right. And the physicians, of course, wouldn't  
17 object to that, in all likelihood.

18 Similarly, setting up a TIN just to dump all your  
19 high-cost, you know, NPIs into -- if done at the  
20 organizational level -- that's quite different from an  
21 individual physician making decisions that may or may not  
22 be in a patient's best interest and may not be in the

1 physician's best interest. They have a patient they like  
2 and they're going to dump the patient to save the ACO  
3 money.

4           So in terms of a question, is there any evidence  
5 that physicians care very much, really, about this ACO  
6 stuff, right? First of all, it's very hard to understand,  
7 even for us, at least for me, and secondly, you know, I  
8 don't know what kind of evidence there is on the sum of  
9 money that an individual physician can get if their ACO  
10 does well, and the extent to which they understand how that  
11 works. I think the sum is really very small, very, very  
12 small in most cases, and the number of physicians who  
13 understand it, even in a rudimentary way, probably is  
14 probably small. They may know, yeah, we should try to keep  
15 costs down, but that's quite different than strategically  
16 trying to select patients.

17           So do you have any evidence on this kind of thing  
18 at all?

19           MR. GLASS: I don't think there is any evidence,  
20 and as we've said, we're looking at vulnerabilities, not  
21 data on has this happened or not.

22           DR. CASALINO: I mean, my concern is --

1           MR. GLASS: And also, I would point out that when  
2 we've done physician focus groups, some physicians aren't  
3 even aware if they're in an ACO.

4           DR. CASALINO: Yeah. So my concern isn't to  
5 defend physicians. I'm just saying there was a comment  
6 from a Commissioner earlier, at the table here, we don't  
7 want to let the tail wag the dog. So I think we have to be  
8 a little careful to think of hypothetical situations. We  
9 know that the gaming is happening with wellness visits.  
10 You guys have evidence for that. But we don't necessarily  
11 know, and it may not even be that plausible, that  
12 physicians would act in the way that was just postulated  
13 here.

14           So I wouldn't want to make policy necessarily  
15 based on hypotheticals that, from all the kind of reasoning  
16 one can put to bear and evidence, if there is any, don't  
17 seem likely to be very prevalent.

18           DR. CROSSON: Okay. What I've got is, I think,  
19 Amol and Dana coming in on this point. Dana, are you the  
20 unnamed Commissioner involved here? Okay. So why don't we  
21 -- and then, Pat, I saw your hand, but you're on the list.  
22 Did you also want to come in on this point? You're up next

1 anyway.

2           Okay, Dana, Amol, and then we'll go to Pat.

3           DR. SAFRAN: Yeah, just a quick question, and  
4 that is, Jeff, in the scenario that you were describing  
5 about, you know, at the beginning of the year if I know  
6 you're likely to need a hip replacement I might, you know,  
7 suggest the compassionate doctor across the street. That  
8 made me wonder about, you know, back on the use of the term  
9 "concurrent," part of what we did was not only have  
10 concurrent attribution but concurrent risk adjustment. And  
11 something in what you said made me think that that's not  
12 happening. And if that's not happening, that is a key tool  
13 to avoiding the scenario that you're talking about. So I  
14 just wanted to flag that.

15           DR. CROSSON: Amol.

16           DR. NAVATHE: On the sub-point of on that point,  
17 so I think the reason that they freeze the ACC's priors is  
18 because otherwise it gives them an incentive to up-code,  
19 basically, a la MA. So that's my understanding of why they  
20 don't do their current coding risk adjustment piece.

21           DR. SAFRAN: Yeah, but the incentive -- you get  
22 bad incentives -- the incentives are worse the other way.

1 DR. NAVATHE: Yeah. I'm explaining my  
2 understanding of the rationale, not defending it per se.  
3 But I think there's a trade-off there, if there's one  
4 incentive in one direction and one incentive in the other  
5 direction. Brian, did you want to comment?

6 DR. DeBUSK: Well, just on that point, I still  
7 think full risk coding is inevitable. I mean we can fight  
8 it, we can push it back, but it's sort of like democracy.  
9 You know, it's the worst form of government, except the  
10 other forms that have been tried from time to time. So  
11 it's inevitable. I'm just sitting here waiting for it.

12 DR. JAFFERY: Very quick, I think one thing that  
13 hasn't come up about any wellness visits is that I think a  
14 lot of ACOs use them as a strategy for coding, getting  
15 people in, and less, though, about attribution.

16 DR. NAVATHE: Fair. So the point I was going to  
17 make is I think, if I read the literature right, and David,  
18 I know some of your colleagues have done some work on this  
19 too, and there's some passionate debates that have been had  
20 around selection and ACOs, the sense I get is to Larry's  
21 point. There is not a lot of evidence, if any at all,  
22 around sort of physician-level behavior changes that may be

1 pernicious in some way, but that there is evidence now --  
2 there may be some debate around it but there is some  
3 evidence around ACO-level, you know, a la what you're  
4 describing here a little bit, in terms of which physicians  
5 are in and which physicians are out, TIN creation, and the  
6 like.

7           And, in fact, I think the other thing that might  
8 be interesting here is to talk to ACO operators, because I  
9 think in a couple other venues that I have heard this topic  
10 discussed there have been ACO operators who have described  
11 strategies that they've used to try to succeed under the  
12 program, and I think some of them do have elements of  
13 thinking about strategically how we would use TINs or NPIs  
14 or manage higher -- you know, physicians who have higher  
15 intensity panels or something like that.

16           And so I was wondering if we've considered doing  
17 any kind of discussions with the ACO groups or the ACO  
18 trade organization to try to get some sense of how much of  
19 a problem this is to the stability of the program, as a way  
20 to complement some of the analytic exercise, recognizing  
21 that the analytic exercise has some obvious intrinsic  
22 limitations.



1           MR. GLASS: We certainly have spoken to both  
2 individual ACOs and the ACO organization, but, you know, I  
3 don't think they're -- and there are also studies, I think  
4 the RAND study, where ACOs did say they were engaged in  
5 some of these things. But normally they wouldn't say,  
6 "Yeah, we're doing this," you know. That wouldn't be  
7 likely.

8           DR. NAVATHE: Yeah. I think --

9           MR. GLASS: But yes, we do talk to people.

10          DR. NAVATHE: -- it would have to be -- I agree,  
11 it would have to be sort of delicately handled. But I  
12 think that -- I guess I may have misinterpreted something  
13 that you guys said. It sounded like you were saying there  
14 was no evidence of any of this broad types of selection,  
15 and so I thought that that was -- that there may be some  
16 evidence and, hence, there's some greater depth here.

17          DR. STENSLAND: I think to Larry's direct point,  
18 I don't think we have specific examples about individual  
19 physicians trying to dump expensive patients. And I think  
20 that's a good point. We have enough other examples that we  
21 can use. But we do hear, and there are some cases in the  
22 literature, of being strategic with your TINs and how

1 you're billing people in or out of the ACO. So that  
2 addresses kind of both of your --

3 DR. CASALINO: [Off microphone.]

4 DR. CROSSON: Okay. Pat.

5 MS. WANG: At the risk of sounding a little  
6 cynical, to Larry's point, I think that even in the absence  
7 of, you know, like a chapter-and-verse detailed sort of  
8 report on different kinds of behaviors, can comment about  
9 ACOs because the incentives are a little less direct. But  
10 sometimes the organization is the physician, and I can tell  
11 you that in the capitated world this happens, and it's  
12 something that you have to be very -- I'm just telling you  
13 it happens, when physicians are at financial risk. And  
14 maybe it's true of larger organizations, but all I'm saying  
15 is hopefully we hope that it's around the margin.

16 DR. CASALINO: When you say "capitated world," do  
17 you mean a lot of risk for the individual physician?

18 MS. WANG: Yeah. Yeah.

19 DR. CASALINO: Well, that's the difference --

20 MS. WANG: So, yeah. So the financial stakes are  
21 much higher.

22 DR. CASALINO: Yeah, I think we know from the

1 '90s that if there's high financial stakes for individual  
2 physicians they would do something like Jeff had  
3 hypothesized. But that's not the way it is in ACOs.

4 MS. WANG: I don't know about that, Larry. I  
5 mean, there are physician ACOs that earn substantial  
6 bonuses, and it's real money to them. So, you know, I'm  
7 just --

8 DR. CASALINO: Well, that's where it would be  
9 nice to have some evidence that, you know, how many  
10 physicians are at all likely to get more than like \$1,000 a  
11 year from their share of shared savings? I would suspect  
12 the number is very low. That's quite different from the  
13 kind of capitation in the '90s was put on individual  
14 physicians. We know that then there were extreme behaviors  
15 from physicians, I agree. But I would argue that this is a  
16 very different situation.

17 MS. WANG: It may be. It may be.

18 What I wanted to ask was, you know, I was a  
19 little bit confused because these are two important  
20 recommendations that you've made here. I wanted to ask you  
21 about the degree to which they do or do not overlap and  
22 have interdependencies. And of the two, TIN versus NPI, or

1 prospective/retrospective, whether you have an opinion  
2 about which is more important to ensure, or tighten up the  
3 integrity of the program? Because I think that's what  
4 you're trying to do.

5           But is there a relationship between the two? If  
6 you fix the TIN/NPI issue, which I think we all kind of see  
7 potential. Even though we may or may not think that it  
8 actually is being exercised, you see the potential. If you  
9 fix that, would the prospective/retrospective be as much of  
10 concern as these two completely freestanding issues?

11           DR. STENSLAND: I think of them kind of as  
12 freestanding. I think of the TIN/NPI issue mostly about  
13 moving physicians in or out of your ACO in a way that is  
14 advantageous, you know, to keep your benchmark high and  
15 your performance spend low by moving these guys in and out.  
16 And I think on the retrospective/prospective, that's more  
17 about moving the patients in or out. If I have the  
18 retrospective or call it "concurrent" assignment, I have  
19 more ability to control a favorable selection of the  
20 patient movement.

21           DR. CROSSON: Brian.

22           DR. DeBUSK: Just on that one point, it may be

1 interesting to look at specifically low-revenue ACOs that  
2 are physician-led who have implemented a two-TIN or multi-  
3 TIN strategy, because that might be an interesting subgroup  
4 to see if the behavior like Pat's describing is there. And  
5 it should be really easy because you could pick their TINs.  
6 It's all claims-based.

7 DR. CROSSON: We are still on questions. Go  
8 ahead.

9 MR. PYENSON: A couple of questions. If risk  
10 adjusters were perfect --

11 [Laughter.]

12 MR. PYENSON: -- then perhaps many of these  
13 issues would be resolved. And I'm wondering if you could  
14 address that, maybe some case examples, because I suspect  
15 people looking at this might be confused about why risk  
16 adjustment doesn't work. Of course, the benchmark, you  
17 know, we talk about sick patients, or I'll use the term  
18 "high-cost or "low-cost patients," and, of course, risk  
19 adjustment will take account of some of that. But just the  
20 variability is one question, if you could -- it is a  
21 question, if you could come up with illustrations on that.

22 But the other question I have is, you know,

1 thinking about risk adjustment and, you know, Carol Carter  
2 had created a risk adjustment or a system for thinking  
3 across sites of service, and I'm wondering if a risk  
4 adjuster or an adjustment for leavers or stayers or  
5 switchers would fix some of the problems even with  
6 prospective attribution or if that's just too far. And  
7 maybe attribution itself is flawed and can't really be  
8 fixed.

9           You know, I'll make a comment on that in the  
10 second round, but I'm wondering what your thoughts are on -  
11 - you know, you've identified some pretty big issues on  
12 here, and is it fixable, in your opinion?

13           MR. SERNA: So I'll take the second half of that.  
14 I don't think you can do an adjustment for stayers,  
15 leavers, or joiners because on the non-ACO side you don't  
16 have a collection of comparable entities, right? So then  
17 you're essentially only adjusting on the ACO side, so  
18 you're basically giving them higher risk scores than you  
19 would for the non-ACO population. So I don't think that  
20 that would work.

21           On the question of why risk adjustment doesn't  
22 handle this, obviously given the example that Jeff gave, it

1 does handle it better prospectively because you have a year  
2 delay and the claims used for risk scores. It'll never  
3 completely adjust because it's what the beneficiary's  
4 characteristics spending would be on average, right? So  
5 you have adjustments to the model such as the condition  
6 account from the 21st Century Cures Act that should also  
7 help beneficiaries who have more conditions, have more  
8 accurate scores, so that may be better reflected. But it's  
9 never going to be perfect because it is linear.

10 DR. CROSSON: Karen.

11 DR. DeSALVO: I just wonder if you could say  
12 something about whether you think any of these solutions --  
13 retrospective, prospective, TINs, NPIs -- helps with the  
14 additional challenge of a beneficiary being in multiple  
15 alternative payment models.

16 MR. GLASS: I don't think we sorted through that  
17 question, though if it's prospective, at least you can say  
18 at the beginning of the year this person's in an ACO and,  
19 therefore, can't be assigned -- can't be counted for, you  
20 know, all the other ones that they've dreamt up.

21 DR. CROSSON: Okay. So what we want to do now is  
22 to provide -- sorry.

1 [Comment off microphone, laughter.]

2 DR. CROSSON: We want to try to provide guidance  
3 to the staff so they can come back to us in the spring with  
4 some recommendations that we could vote on. And so what I  
5 basically would hope we could do here as we go through the  
6 discussion period is have people express support or lack of  
7 support for, you know, one or the other of the two choices  
8 in these two categories of assignment that we're dealing  
9 with, so we get a sense of whether we're sort of tending in  
10 one direction or the other or not, and that would then, if  
11 we're not, mitigate perhaps some different approach. So,  
12 Jonathan, I think you're going to start off.

13 DR. JAFFERY: Sure. Thanks, Jay.

14 There's a lot to unpack in this conversation, and  
15 I'm left feeling -- this may sound a little Pollyanna-ish,  
16 but I feel a little sad for ACO operators who get up in the  
17 morning and think about how do we switch people from TIN to  
18 TIN as opposed to how do I build this piece of the care  
19 model that is actually trying to achieve the intended  
20 goals. And I'm going to continue to believe that most  
21 people are in the latter bucket, but maybe I would run of  
22 those dumb ACOs.



1           So, first of all, I really appreciate the  
2 evolution of this conversation around the prospective  
3 versus retrospective assignment, and I think, you know, as  
4 -- I feel a little more comfortable, a little more like I  
5 have a little bit better understanding of the perspective  
6 and how this may help decrease the gaming opportunities as  
7 we have each conversation.

8           That said, I think Round 1 brought out a number  
9 of questions that are still -- that still may require us to  
10 have a little bit more clarification on how this might  
11 impact different scenarios. And I think, you know, Pat's  
12 comment about do these two things intersect or overlap in  
13 any way I think is an important one, and I think -- I don't  
14 know. The TIN/NPI or the NPI conversation is sort of a new  
15 one, and so I think thinking through that a little bit  
16 would be helpful.

17           That said, I think this NPI recommendation -- I'm  
18 not -- you know, I liked the evolution from TIN to TIN/NPI,  
19 and I think this one has some merit. And I don't see --  
20 I'm not seeing necessarily a significant amount of downside  
21 to doing this, as long as you do address the things that  
22 you bring up in the chapter which are how do we exclude

1 people who, you know, have a large -- basically who move or  
2 things of that nature.

3           So I think, you know, getting to this other  
4 question about what other ways to deal with beneficiary  
5 assignment or attribution, you know, Bruce brought up --  
6 started to allude to and it sounds like you've got some  
7 comments that you'll make about how are we thinking about  
8 this the right way. And I think there are a couple things  
9 to think about. Maybe some of them are more granular, like  
10 the specialist attribution. Is that something that we  
11 should even have? And how much is that impacting  
12 attribution in ACOs?

13           I also think about, you know, we've been talking  
14 about bringing people for annual wellness visits or  
15 bringing people in for multiple visits, the attribution and  
16 the pros and cons there. You know, a lot of the model  
17 we've moved to is to try to be accountable for a population  
18 of patients without necessarily having to always rely on  
19 seeing them face to face continuously. And so there are a  
20 group of patients that we may take some accountability for,  
21 or we may ask our providers, our primary care providers, to  
22 take accountability to make sure that they're getting their

1 preventive care needs and things like that and available  
2 for interaction for relatively straightforward or minor  
3 things where maybe the physician and the patient have a  
4 relationship that goes back many, many years, where we are  
5 doing this more and more through non-face-to-face means.

6           Are we still accountable for them? We are. And  
7 sometimes, you know, things happen out of the blue, where  
8 people who have been healthy for a long time, and we can  
9 even do things where sometimes if somebody's got a  
10 relatively straightforward -- you know, somebody's got  
11 hypertension that has been longstanding and easy to  
12 control, do we necessarily need to bring them in every year  
13 just to make sure that they're okay?

14           So I think that, you know, when we think about  
15 the capitated world, one of the benefits to that for the  
16 organization is to say, well, we're actually going to be  
17 accountable for a group of patients that may not need a ton  
18 of care, and that may balance out the patients who need  
19 more care. And so I think as we move towards -- as some of  
20 these models move towards some of that global kind of  
21 budgeting or capitation, we're going to have to think more  
22 about what attribution models make sense.

1           I guess the other thing I want to take maybe a  
2 step back for a second and think about -- oh, one other  
3 thing about the attribution in addition to the specialist.  
4 There's also the APP attribution, and because in the past  
5 the APPs have not been able to discern between primary care  
6 and specialty care, that has played a role as well for  
7 trying to -- how do we include people or not include people  
8 are participants.

9           I want to take a little step back, though,  
10 because I think that these conversations are really focused  
11 on how do we stabilize the program at a pretty granular  
12 level. But I was really struck when I was looking at the  
13 appendix in the reading and thinking about how we have had  
14 -- we're about nine years into ACO models now, right, if we  
15 exclude PGP? So we're about nine years into it. And there  
16 were two things that struck me when I was looking at that.

17           So, first of all, you know, you brought this up  
18 in the presentation. We've got a 1 to 2 percent savings if  
19 we're using counterfactuals, and we sometimes refer to that  
20 as small savings or modest savings. And I can't get a  
21 sense of if we as a society or as a Commission think that's  
22 a good thing. Is that a success or is it not? Because

1 sometimes it comes off as, well, this is too small and it's  
2 not enough or we're not going quickly enough.

3           On the other hand, I don't know of any other  
4 program that we talk about where we're doing anything, and  
5 Medicare Advantage we've talked about as adding costs to  
6 traditional fee-for-service. So I guess I just want to put  
7 that out there, that that's not clear to me always that if  
8 we think this is a success and what we think is a realistic  
9 goal, even the short term.

10           The other thing is just to think about how many  
11 different models we've had in nine years and how difficult  
12 this is to operate under this lack of stability and this  
13 uncertainty. And now we've got, you know, a third of the  
14 population, we've got over 10 million people. We may be  
15 seeing some instability. As you mentioned, the number of  
16 ACOs has grown until 2019, and it decreased. It was  
17 modest, but that was the first time it went down. And  
18 these models keep turning over.

19           And so we look at NextGen as an example, so it's  
20 not the MSSP model, but that's a demonstration model. It's  
21 a small group of organizations that there seems to be some  
22 success there, and rather than sort of building on that in

1 a way that I think would help organizations that are  
2 involved in those models, take things to the next level,  
3 move things toward some sort of more global payments, we're  
4 now moving to an entirely different model, direct  
5 contracting, which is described as the next step for  
6 NextGens. But, you know, to date, there is so much  
7 uncertainty there. You know, our colleagues, other  
8 Commissioners, who either run NextGens or have -- I think  
9 Warner's in the MSSP ENHANCED, so they're not here right  
10 now to comment. But having talked to them and others,  
11 there's a lot of uncertainty about whether or not we can go  
12 into this next model. And I will tell you that it's very,  
13 very challenging to try and implement long-term innovation  
14 when you're spending every couple years trying to figure  
15 out what the next program is and trying to explain that to  
16 your senior leadership and trying to model things out.

17           So while I applaud you for digging into these  
18 issues, and I think we need to continue to think through  
19 them, I guess I'd like to see us try and find -- strike a  
20 different balance between how much we get into the granular  
21 aspects of existing models or changing models and how much  
22 we're going to -- how do we stabilize this? Because after

1 a decade, it feels like it's starting to have the potential  
2 for unraveling a little bit. Thanks.

3 DR. CROSSON: Okay. We're going to go on to the  
4 discussion period. Let me see. I think we're going to  
5 start with Bruce, who already volunteered he has something  
6 to say, and then Dana, Brian, and David.

7 MR. PYENSON: Well, thank you very much for your  
8 work, and I think it's really among the most important  
9 things that we've done and you've done.

10 In thinking about the ACO movement, I think  
11 historically it has often been seen as capitation lite and  
12 a way to create something that was like capitation but  
13 without the beneficiaries or, in the case of commercial  
14 insurance, the members knowing about it and without as much  
15 rigor on the part of the provider systems. So the  
16 attribution methodologies were a way to define, if you  
17 will, a natural assignment of capitation and to create  
18 virtual budgets and virtual gains and losses based on the  
19 virtual budget. And I think what you've identified in your  
20 work are some flaws in that that probably were not foreseen  
21 by most of the people involved in thinking about how those  
22 programs would work and the risk selection issues and the

1 vulnerabilities of that.

2           So we're at a point today where perhaps the  
3 question is: Does capitation like or attribution methods,  
4 do they really work? Or are there too many challenges with  
5 them that make it mean we have to get to something more  
6 direct? I think that's perhaps not as much of a challenge  
7 as we might think.

8           Part of the appeal of attribution has been a  
9 belief by providers that bringing special focus on  
10 particular patients identified in advance would bring  
11 advantages and better outcomes and lower cost. And I think  
12 there's been a series of tests of that hypothesis, most  
13 recently the work that was done on hotspotting or the  
14 Camden approach. But there's been a whole series of other  
15 tests of that that have shown that that hypothesis probably  
16 isn't right or broadly isn't right.

17           But I think that's actually good news for the  
18 test at hand, which is, to pick up on what Jonathan said,  
19 perhaps a direct relationship between the physician and the  
20 patient isn't as important as many people think, that what  
21 really counts is what the system brings to the individuals.  
22 So if that's the right answer, then I think that's good



1 news for what we're trying to do because it means that  
2 having ACOs accountable for a fixed population, regardless  
3 of where they get their cost, probably isn't as crazy an  
4 idea as some might think.

5           So I think where we're heading here with this  
6 information is a different model of ACO which looks a lot  
7 more like Medicare Advantage perhaps or capitation, where a  
8 provider system is responsible for the patient that's  
9 assigned to them no matter what. Some of those patients  
10 are going to be seen personally, and others are just going  
11 to be there. And I think what -- I'm interpreting the  
12 results here as a step towards a perhaps better model and  
13 one that's simpler and one that's better connected to the  
14 evidence of what works and what doesn't work.

15           So I think the work you've done has really been  
16 fantastic and paved the way for the next steps for  
17 accountable care. So thank you very much.

18           DR. CROSSON: So, Bruce, let me just thank you  
19 for pointing out to the Commission and also to our guests  
20 that we currently have two levels of work going on here  
21 with respect to ACOs. One is, I think, well represented by  
22 what you've said, and I think that's a longer-term piece of

1 work; and one that, as we mentioned, we're going to be  
2 coming back to in the spring, which would include, I think,  
3 some more comprehensive changes to -- and I'll call it the  
4 "ACO program," but I think as you suggest it's broader than  
5 that. It's how to get a payment system that rewards the  
6 successful management, cost, and quality of a population.

7           Another level of work which I think the  
8 presentation today gets to is, given all that, you know,  
9 how do we repair the flaws in the engine of the car that  
10 we're currently driving, not to stretch the car metaphor  
11 beyond where it should be, but, you know, we have to give  
12 attention to both levels of engagement at the same time.  
13 So I think it would be helpful, you know, again, to try to  
14 provide to the staff some suggestions about which of these  
15 four choices people might think they are supportive of.

16           Dana.

17           DR. SAFRAN: Thank you.

18           I'll start with the NPI issue and say that I'm  
19 very supportive of moving in a direction that uses NPI tied  
20 to ACOs. I personally don't see the value of including the  
21 TIN in the mix, and from this conversation, I see a  
22 multitude of mischief that could happen when that occurs.

1           Given the way that attribution works, which thank  
2 you, team, for clarifying that really is -- I think you  
3 said 90 percent primary care physicians, 10 percent  
4 specialists but only in six medical specialties. I do  
5 think that simplifies what otherwise could be a kind of  
6 mind-bending expertise for surgical specialists who might  
7 practice in different settings that are associated with  
8 different ACOs.

9           So I do support that idea of using NPI and having  
10 NPI tied to just one ACO for physicians for whom there can  
11 be attribution, if that makes sense.

12           On the attribution model, I have to say that I  
13 still have a lot of concerns about "prospective." One got  
14 added to my list by Jonathan's comments about just  
15 stabilizing the program, so that I'll add that to my list  
16 of reasons.

17           My main reason is that, as I think my earlier  
18 question probably indicated, we do know that part of health  
19 care works, and I don't think we're trying to change this,  
20 is when patients have a significant health care need, they  
21 may move to a different system. I know that it's true that  
22 currently -- that in MA, the way that works is you are the

1 plan, and you are accountable, regardless of where care  
2 happens.

3           ACOs are meant to be different. ACOs are not  
4 plans. They're delivery systems, and so I think I'll paint  
5 the picture of my concern. And it relates to the  
6 conversation we had yesterday about transforming hospital  
7 payment in a way that is going to become clear in a second.

8           So patient is part of right now ACO A, and there  
9 is ACO B that has expertise in, let's say, the particular  
10 health condition that emerges in April of that calendar  
11 year. Under a model where the patient remains ACO A's  
12 accountability, no matter what, the hospital in ACO B's  
13 contract is riding their fee-for-service horse when they  
14 are taking care of that patient. They have no  
15 accountability for managing the cost of that case, and ACO  
16 A has really very little ability to influence that  
17 hospital, other than starting to try to dramatically shift  
18 the referrals they make in general for their population to  
19 hospitals that are more cooperative, but given this being  
20 the Medicare program and patients being able to go where  
21 they like, I think that's part of our problem.

22           On the other hand, if what manifests is that ACO

1 B's hospital and physicians are really the best place for  
2 this patient to get care for what's going on with them this  
3 year, then I really do think that a model that says this is  
4 where the patient is getting care this year and this is who  
5 is accountable is a very good model.

6 I think the other thing that we came across in  
7 this conversation that I think is important to add is that  
8 not only is it concurrent attribution, it's concurrent risk  
9 adjustment. If the risk adjustment model is tied to last  
10 year, you get a multitude of concerns.

11 I guess the last thing I'll say is that the  
12 worries about December wellness visits and so forth, I  
13 think, are really quite small compared to, I think, the  
14 significant worries that we should have about patients with  
15 significant health needs and where they get their care and  
16 who's accountable for making sure that care is good  
17 quality, getting the best possible outcomes and managing  
18 the overall cost of the episode.

19 So thanks.

20 DR. CROSSON: Thank you, Dana.

21 Brian?

22 DR. DeBUSK: First of all, thanks again for a

1 great chapter. I really, really like the technical work  
2 that you guys do. I really enjoy seeing us in this more  
3 and more too in making ACOs successful. So thanks you.

4           Specifically on the NPI approach, with the  
5 delineation between an NPI used for assignment versus a  
6 participating NPI like we discussed in the clarifying  
7 round, I definitely think NPI is the way to go. I mean I  
8 think philosophically, technically, for a lot of reasons.

9           Also, on the prospective attribution, that makes  
10 a lot of sense. I think, again, your technical work there,  
11 you've built a good case using the leavers and switchers  
12 and stayers analysis. So I think you're definitely moving  
13 in the right direction there, so, again, two excellent  
14 technical fixes.

15           I want to mention sort of the next round of  
16 technical fixes. I mean, Dana just mentioned it. I think  
17 Amol mentioned it earlier. This risk adjustment thing, if  
18 I had to pick two sort of elephants in the room, risk  
19 adjustment and beneficiary engagement, at some point, I  
20 think we're going to have to take those up. I feel like  
21 we're sort of avoiding two difficult subjects, and I don't  
22 blame anyone for avoiding them. But I also feel like

1 they're inevitable.

2           To speak on beneficiary engagement for minute, we  
3 talk about 10 million people in ACOs. I'll bet 9.9 million  
4 of them don't know they're in ACOs, and I think that's  
5 fair. Yeah. I think that's a good example of the  
6 challenge. You've got to have some mechanism to engage  
7 your beneficiary. So many of them are protected from cost  
8 sharing. So I don't know that you can use that lever. I  
9 don't know if it's Part B premium. I don't know what's  
10 left, but I think we are going to have to at least visit  
11 that subject.

12           The last thing I want to touch on -- and I'll try  
13 to be really brief -- anytime we provide, either  
14 intentionally or unintentionally, an opportunity, let's say  
15 an arbitrage for physicians or for providers, they adopt  
16 those remarkably quickly. I mean weeks, months, certainly  
17 not years, to make adjustments to the practices.

18           So let's look at this program. We're nine years  
19 in. They've got this tremendous degree of freedom around  
20 managing the patients that are assigned to them right now.  
21 They also have this tremendous degree of freedom around  
22 managing the providers that get attributed to them or

1 associated with them. So you've got these two huge degrees  
2 of freedom.

3           Jeff, I think that's what you described it as, as  
4 sort of two independent degrees of freedom.

5           If you look at what we're going to publish in  
6 March, we pay 91 cents on the dollar to a hospital and  
7 contribute 8 percent toward their fixed cost. You back  
8 into that. That means 86 percent of their costs are fixed.  
9 That's just to make the math tie.

10           So I'm thinking you've got these two tremendous  
11 degrees of freedom in this program that's nine years old,  
12 and they get to shed 86 percent of their costs and then get  
13 48 percent of that cost back in shared savings through the  
14 50 percent shared savings. And I don't mean to be -- I  
15 love ACOs, and I want to see them successful, but I'm  
16 asking myself, shouldn't we do some soul-searching? I  
17 mean, you would think we'd be having meetings talking about  
18 how we have to pare these savings back, and how do we slow  
19 this program down?

20           We've had these very tepid results in a program  
21 that has some pretty well-documented vulnerabilities. In a  
22 system to shed 86 percent of the cost and get 48 back, I



1 mean, that's a 38 percent margin swing in a 5 or 6 percent  
2 margin industry.

3           Jaewon ought to have a van driving around town  
4 picking up patients for the ACO. I don't mean to be  
5 pejorative.

6           But let me plant a bug here, one last thing.  
7 I've gone way too long. If the world isn't working the way  
8 we think it should if we've got this idea -- Bruce touched  
9 on this with this new start of going "hotspotting." Either  
10 the idea of care coordination and the idea that we can  
11 actually cooperate, communicate more in all this and reduce  
12 cost, either that idea doesn't really pan out or at least  
13 doesn't work nearly as well as we thought it would or our  
14 underlying assumptions are wrong, and I still keep coming  
15 back to everything we've done in the ACO space is built on  
16 top of fee-for-service. And is it time to either question  
17 care coordination, which I still believe in, or is it time  
18 to question the assumptions that we're going into this  
19 experiment with? Because or both of those are wrong,  
20 unless Bruce wants to disagree with me. One or both of  
21 those are wrong, and I would just encourage us to look at,  
22 explore things like global budgets and some form of

1 capitation and really changing the way hospitals and  
2 physicians are paid.

3 Thanks.

4 DR. CROSSON: Thank you, Brian.

5 Marge, on this point?

6 MS. MARJORIE GINSBURG: Yes.

7 DR. CROSSON: And Dana as well.

8 MS. MARJORIE GINSBURG: I felt we were told last  
9 year that CMS was going to be notifying all ACO enrollees  
10 that they were in an ACO. They were going to be sending  
11 letters out. We heard that, I think, at our last July  
12 meeting. Did I dream this?

13 MS. TABOR: The ACOs are now required to submit  
14 letters.

15 MS. MARJORIE GINSBURG: The ACOs?

16 MS. TABOR: Yes.

17 MS. MARJORIE GINSBURG: Are they doing it?

18 MS. TABOR: They are. It's probably too early to  
19 say what the results are because it's too new, but I'm  
20 tracking it, so one more report. But, yeah, there is a  
21 requirement now that ACOs have to both send a letter,  
22 notifying beneficiaries that they're in an ACO, and then

1 also I believe posters or banners or some kind of  
2 notification within some buildings.

3 DR. JAFFERY: That was the original. That used  
4 to be the case that ACOs had to do that. So we did that  
5 for years. We didn't have to anymore, and now they have to  
6 again. So it's not a new thing, and so it's maybe early to  
7 see what happens here. But it didn't seem to impact  
8 beneficiaries' ability to know that --

9 MS. MARJORIE GINSBURG: [Speaking off  
10 microphone.]

11 DR. JAFFERY: There was a very small subset that  
12 would respond usually by writing a letter back. Yeah,  
13 usually without a lot of understanding of what it means.

14 DR. CROSSON: Dana?

15 DR. SAFRAN: Yeah. On this point too. I was  
16 going to pick up Bruce's point but decided not to, but now  
17 I feel like I need to.

18 The New England Journal article this week about  
19 the hotspotting is a very important piece of research. It  
20 should not undermine our confidence in decades of research  
21 that show definitively that clinical relationships matter,  
22 that clinical relationships influence patient behavior.

1 This is a study of extreme population in terms of poverty  
2 and social need, and it should not surprise us that care  
3 coordination isn't on their Maslow's hierarchy of needs,  
4 the thing that's going to make the difference. They need  
5 housing. They need food, and that article should both  
6 accelerate our attention to social determinants of health  
7 and the important bringing together of social care and  
8 medical care. But it really should not for the broad  
9 population, including Medicare beneficiaries, undercut our  
10 confidence in the evidence that coordinating care for  
11 people who have complex medical needs is critical and that  
12 the clinical relationships matter immensely, because  
13 adherence to clinical advice is on the pathway from what  
14 happens in the clinical encounter to whether you get good  
15 results. And we know that patients adhere to those whom  
16 they trust and those they feel know them. So I just wanted  
17 to punctuate that.

18 DR. DeSALVO: Amen.

19 DR. CROSSON: Thank you. Dana.

20 Okay. So Jonathan, and, Brian, you want to  
21 comment on that. David is in the bullpen here.

22 DR. JAFFERY: Yeah. First of all, Dana, thank

1 you for saying that. I couldn't have said that better.

2 That was amen, indeed.

3 I think maybe connecting that and also to Brian's  
4 similar comments about beneficiary engagement, I'm not sure  
5 I always understand what people are saying when they're  
6 talking about the beneficiary engagement gap, and I think,  
7 in some ways, the need here is to try and find that balance  
8 between what is an ACO team doing to building the structure  
9 to provide support, ideally to provide support for building  
10 that team-based model of care, so that primary care in  
11 particular has other resources to deal with folks with  
12 behavioral health in the clinic and whatnot, and then  
13 ultimately, more and more, try to move upstream to how do  
14 we get involved in social determinants of health. That's  
15 one of my reasons for wanting more stability in the  
16 program, so that you're not reinventing the wheel every  
17 three years and not dealing with those things.

18 But I think the other thing is that's the role  
19 maybe of the ACO structure more. The individual physicians  
20 and other providers are still the ones that have that  
21 relationship with the patients, and to me, that's the  
22 beneficiary engagement part. People tend to stick with

1 their primary care doctors, and I take my job with the ACO  
2 as supporting that team.

3 DR. DeBUSK: Just to clarify that other comment,  
4 I also believe in care coordination, and that's  
5 interesting. I knew sort of who the care coordinators  
6 would be, who would speak up when I made that comment.

7 Here's my point. We've had nine years for this  
8 ship to come in, and I still believe in the idea. The  
9 question is, especially for the people who believe in care  
10 coordination, are we building these models on top of the  
11 wrong chassis? Because that's the only other answer.  
12 Either it doesn't work, because it's had nine years to  
13 work, or we're building it on the wrong chassis.

14 Thanks.

15 DR. CROSSON: Okay. David and then John.

16 DR. GRABOWSKI: Great. Thanks.

17 So I'm pleased that we're continuing to focus on  
18 ACOs. I'm a little bit worried that we're losing the  
19 forest for the trees to some extent. I guess I'm less  
20 concerned with assignment issues and more concerned with  
21 that uncertainty that Jonathan expressed.

22 I agree selection is a problem, but I think it's

1 a problem if the Jonathans of the world leave the program.  
2 I'd like to see us focus on incentives to participate, to  
3 save and select, and to kind of think about the big policy  
4 issues and focus. I just don't see assignment as being a  
5 huge first-order issue.

6           So let me say a couple of words about the two  
7 points in the chapter and then make some broader comments.

8           Regarding prospective versus retrospective, my  
9 view on that is there's tradeoffs with both. I'm fairly  
10 indifferent. I actually think prospective just delays a  
11 lot of these incentives by a year, and ultimately, we get  
12 to the same sorts of behavior. You could convince me, and  
13 I'd be receptive to kind of going to prospective, but I  
14 don't think that's going to solve our problems here. So  
15 I'm not convinced that that's a huge area of focus for us.

16           On the TINs versus the NPIs, I'm glad, Bruce,  
17 that you raised risk adjustment. I think that's a huge  
18 issue. I think this could be solved by risk adjustment,  
19 that we should as a Commission be kind of making  
20 recommendations and investing in better risk adjustment.  
21 The ACO CAHPS is an example of one survey that we might  
22 leverage. So there are other ways to do this better, and

1 could we be pushing on that front?

2 I don't know. Once again, I don't have strong  
3 thoughts on the TINs versus the NPIs, but I just don't  
4 know. I'd rather see us focus on risk adjustment than kind  
5 of the leveling there.

6 The final remark is I do believe -- and Jonathan  
7 talked about the kind of enrollment decline in this year.  
8 I do think the program is starting to unravel. ACOs can  
9 leave the program or jettison TINs to get under the  
10 regional benchmark. I think the real problem is kind of  
11 this regional benchmark coupled with this shift, as you  
12 mentioned during your presentation, slowly towards downside  
13 risk. I think we want to really revisit and focus as a  
14 Commission on how we're setting the benchmarks and thinking  
15 about the structure of risk in the program. I'd like to  
16 see us go after the high-level issue and not focus  
17 necessarily on assignment.

18 Thanks.

19 DR. CROSSON: Jon?

20 DR. PERLIN: Let me associate with David's  
21 comments and just as a bit of a segue into the difference  
22 between sort of looking at the population overall and then



1 this issue of care-spotting, care coordination.

2           You say okay, the ACOs, that the results have  
3 been modest. Maybe that's true on average, but folks who  
4 work with me in my office know my favorite Lincoln quote is  
5 "A man with is hair on fire and his feet in ice water is,  
6 on average, comfortable."

7           [Laughter.]

8           DR. PERLIN: And the extremes are very, very  
9 different.

10           There may be some patients who are intense  
11 utilizers. One of the things I would have liked to have  
12 seen and I hope we'll take up as an adjunct to this is to  
13 really push CMMI to offer some models that look at those  
14 extreme utilizers, the extreme risk, because it may be that  
15 the average is belying a couple different populations, a  
16 population once held that we've had some conversation about  
17 that really doesn't need much, and good for them; the  
18 population in the middle who will be somewhat represented  
19 by that 1 percent, and a population that will be extreme  
20 utilizers and if not managed -- and this is the way I  
21 thought about it in VA -- deprive the number of  
22 beneficiaries that can be served or the depth of service to

1 any particular beneficiary.

2           If one can identify the risk adjustment, it has a  
3 couple of implications. First, that you begin to build the  
4 ACO around the beneficiary as opposed to around the  
5 providers, that maps differently, and under perhaps the  
6 aegis of CMMI, that some of the social determinant issues  
7 that are so confounding might be addressed.

8           Let me just cap that with this, that the most  
9 powerful prescription I ever wrote at the VA, in fact, the  
10 most powerful prescription I ever wrote in my life, was for  
11 a window air conditioner for a gentleman with end-stage  
12 COPD who was in and out of the emergency room every two  
13 weeks. Were he not a veteran, he would have been using  
14 Medicare resources, and in Richmond and summer, the inside  
15 of his double wide would get to be about 120 degrees.  
16 After that \$1,200 intervention, his utilization was about  
17 twice per year and without the sort of extreme situations.  
18 So I just think we need to think both about the  
19 distribution of risk and how we apply certain tools,  
20 perhaps pushing the boundaries through CMMI and then what  
21 are the implications for defining the population for care  
22 in an accountable care arrangement around beneficiaries and

1 their risks, perhaps.

2 Thanks.

3 DR. CROSSON: Thank, Jon. Amol and then Kathy.

4 DR. NAVATHE: So I definitely agree with the  
5 broader points that Brian and David and others have made  
6 about the focus on sort of bigger picture and our role in  
7 sort of helping advance that thinking. I think, you know,  
8 Brian sort of alluded to it without really saying it, in  
9 some sense, that maybe the real destination here is to try  
10 to get away from fee-for-service and to a capitation-based  
11 model or something that's more population based in terms of  
12 payment.

13 And so one lens to view this in, I think, is, you  
14 know, are these kinds of technical and/or structural  
15 details, are we moving toward a system, or moving toward  
16 the direction of a true population-based payment type of  
17 model? And it seems to me, in that sense, the prospective  
18 and the NPI, these are all positive shifts for us to be  
19 recommending, because I think most of the capitated type  
20 models do function largely that way.

21 Another sub-point, just to make the bullet point  
22 on the prospective versus retrospective, I totally agree

1 with David and Dana and others that there's tradeoffs  
2 between the two, but I think there is also an important  
3 sort of behavioral, psychological benefit to prospective  
4 attribution for physicians and ACOs and ACO operators  
5 around, you know, feeling like they know who they're  
6 responsible for, and that could be actually huge in terms  
7 of its eventual impact.

8           I think, to come back to the 30,000-foot view, I  
9 think an important question that we have to ask ourselves  
10 is, you know, if we are trying to move this shift towards  
11 population-based payment, and again, Brian alluded to this,  
12 is, you know, are we doing enough? Are we dialing it up  
13 enough? But I think another question that comes up over  
14 and over again is, you know, what are the capabilities  
15 needed to be able to really succeed in those models. And I  
16 think most of us would probably feel like turning on a two-  
17 sided model for the entire nation in a mandatory fashion  
18 would probably not be the right way to go, because we just  
19 probably don't have the right capability.

20           And I think that's the direction, in some sense,  
21 that we need to think about, is if we're going to move away  
22 from the system that is inherently flawed, that is

1 inherently not driving the right types of incentives, and,  
2 frankly, not delivering for our beneficiaries, then what  
3 are the steps that we need to make, from a structural  
4 perspective, to actually bridge this gap so we can get the  
5 delivery system to a place where it can handle a  
6 population-based type payment model that probably most of  
7 us feel is the destination that we're really searching for.

8 DR. CROSSON: Thank you. Kathy.

9 MS. BUTO: So when I -- I actually don't have a  
10 strong opinion on these issues, but I was inclined to  
11 support the recommendations to move toward an NPI versus a  
12 TIN, and prospective versus retrospective, until I listened  
13 to the conversation.

14 So Dana, actually, I thought, was pretty  
15 persuasive that there is some real value in having the  
16 accountability follow the patient, which makes me a little  
17 more indifferent to which way we go on the assignment  
18 issue.

19 I think the NPI still makes more sense, but I  
20 really liked David and Jonathan's comments about the larger  
21 issues. And I realized that ACOs were originally developed  
22 with the notion that we should try to make coordination of

1 care as painless as possible for the beneficiary.

2           And I wonder if we've reached a point now where  
3 we ought to be willing to step beyond that, to look at a  
4 level of ACO which involves enrollment, not attribution,  
5 and where there still could be shared savings, but begins  
6 to move more in the direction of partial capitation for  
7 some aspects of care. And I would just say I think we're  
8 ready to look a little beyond where we are for those ACOs  
9 that are ready to take a bolder step.

10           And Brian, I know your issue with fee-for-service  
11 chassis, but frankly, you know, I don't see us cutting  
12 loose from fee-for-service until we either have premium  
13 support or some other basis on which to value the care.  
14 Right now it is the data that tells us what care is costing  
15 for Medicare beneficiaries. Until we have another way to  
16 value that, I don't know how quickly we can break that, you  
17 know, move away from that chassis issue, say.

18           But, you know, I think I'm open to that. I think  
19 we all are. It's just what exactly do you have in mind,  
20 and I think that probably needs to really be discussed  
21 among the group.

22           But I just want to say that I think where we're

1 stuck on ACOs is just that it was always going to be an  
2 incremental savings program with the hope of improving  
3 quality. But maybe it's time to look at, all right, time  
4 to evolve beyond that. And beneficiaries are probably  
5 ready for it too, at least for that choice. They can still  
6 choose the less-risky choice.

7 But those are my comments.

8 DR. CROSSON: Thank you, Kathy. Jonathan and  
9 then Larry.

10 DR. JAFFERY: Yeah, I just want to add onto what  
11 Kathy just said, and I really appreciate that perspective  
12 of how do we evolve this.

13 I won't speak to the enrollment piece, but just  
14 to give people a sense, because I recognize that not  
15 everybody is as close to some of the models as I am. And  
16 so in NextGen there is the opportunity for organizations to  
17 move towards more population-based payments. What I hear,  
18 in talking to a lot of colleagues who are in the same  
19 situation, is that they do, in fact, want to go in that  
20 direction or have started to. And, you know, one of the  
21 issues is that NextGen is a demonstration through CMMI, and  
22 this is the last year, the final year to start it.

1 And so direct contracting is designed to be the next step,  
2 but I think my concern is that rather than just taking  
3 NextGen and extending it and trying to evolve it to get  
4 towards some of those goals, which CMMI could do, it's sort  
5 of being replaced, maybe not whole cloth but enough that  
6 it's very difficult, because you're stuck switching into a  
7 whole other space in order to get to that capitulation or  
8 population-based payment.

9           And so maybe there's something that we could  
10 start to recommend towards CMMI that, rather than do that  
11 here's a way we can involve the model in what you have  
12 already created that has actually, for a relatively small  
13 number of high-performing organizations, a fair bit of -- I  
14 would say a significant bit of engagement.

15           DR. CROSSON: Larry.

16           DR. CASALINO: Yeah. I think that, you know, the  
17 issues of assignment and the NPI versus TIN issues are  
18 vitally important in the program, and I have to say I still  
19 feel like I'm ping-ponging back and forth as I hear people  
20 speak. I don't actually have a fixed position. I'm not  
21 going to comment on those now, but people are trying to  
22 kind of set up for the spring work we're going to do, and



1 I'll just make a couple of quick comments about that, I  
2 think.

3           You know, I've been a big supporter of ACOs from  
4 the beginning, and I think that they have been successful,  
5 very much so, in the sense of changing the culture and  
6 what's kind of taken for granted, culture in health care,  
7 which is important. It changed it in the sense that, you  
8 know, there is a sense that we have to change more towards  
9 systematically improving quality, reducing costs. That's  
10 kind of taken for granted. Now it's hard to remember,  
11 maybe even though it wasn't, 10 years ago, but I think if  
12 we look at the program now, 9 years is a pretty long time.  
13 And in the Medicare ACO programs, at least, you know, we  
14 don't have a tremendous amount of savings to show for it,  
15 and we don't know that much about the quality.

16           Part of the problem may be that so many of the  
17 ACOs have hospitals at the center of them, and, you know,  
18 the hospitals obviously really have a foot in two canoes  
19 and probably are a barrier, not a facilitator in many cases  
20 to not all but to ACO success.

21           But I think the other problem is the amounts of  
22 money at risk are so small, maybe not so small for an

1 independent physician group that, you know, has 5,000  
2 beneficiaries and is doing it, but for a hospital-based  
3 system or, you know, a large medical group system, very  
4 little money involved. And I think those are two of the  
5 reasons we're not seeing much change.

6           The real point I want to make is that, you know,  
7 we do have examples that worked, for whatever reasons, or  
8 are working. So I think more could be learned from what  
9 Blue Cross Blue Shield's Alternative Quality Contract has  
10 done, and it would be very instructive, I think, to try to  
11 understand the reasons why that worked, how well it's  
12 working, the reasons why it works as well as it does, and  
13 to what extent could Medicare do that or not do that.  
14 There are some advantages that, you know, commercial MA has  
15 that and Medicare doesn't have. But explicitly trying to  
16 learn from that.

17           And then a lot of people in the room, probably  
18 the majority, are too young to probably know much, if  
19 anything, about this, or even know that it existed, but,  
20 you know, more than a quarter of a century ago, in  
21 California and some other places, these were mostly medical  
22 groups and IPAs. The hospitals were not part of this.

1 They were extremely successful at taking large amounts of  
2 risk. And one of the problems with the program now, I  
3 think, is that the amounts of risk that are being taken are  
4 really fairly trivial, in my opinion.

5           It's kind of incongruous to me to -- so I kind of  
6 grew up on the California experience, which was give us  
7 more risk, give us more risk, give us more risk. That's  
8 the way we're making money. That's the way HealthCare  
9 Partners made money, this \$4.4 billion group when it was  
10 bought a few years ago. So part of me still lives in that  
11 "give us more risk" world, and to have very large  
12 organizations, much larger than these medical groups, who  
13 are saying, "Oh my God, you know, we can't afford to take 1  
14 percent downside risk," you know, I think as long as we  
15 don't have more risk we're never going to get very far.

16           So it's obviously true that we can't make the  
17 whole U.S. health care system not take lots of risk. It's  
18 not organized for that. But I wonder if it's worth  
19 thinking about, at least, trying to -- there are still  
20 people alive and there are some publications to try to  
21 learn, how did that -- in addition to learning from Dana's  
22 program, how did that happen in those days? How were these

1 groups successful? How were the programs set up? And are  
2 there any lessons from that at all, if we want to even  
3 think about a larger set of suggestions for the ACO  
4 program, instead of or in addition to making important  
5 technical fixes in the program as it is now.

6 DR. CROSSON: Thank you, Larry. I mean, my  
7 memory of this, because, as you know, I was around during  
8 that time as well, is that a lot of the success was in the  
9 Los Angeles basin, where there's a concentrated population,  
10 and many hospitals are not that very far apart. And so not  
11 entirely but to a large degree, some of the success enjoyed  
12 by the large medical groups there, in taking capitation,  
13 was due to the ability to move patients from one hospital  
14 to the other. And essentially, it's kind of the  
15 opposite situation that we've been describing here where,  
16 in fact, we have hospital-led ACOs who have a different  
17 payment incentive. In that situation, the hospitals are  
18 very strongly incented to play along, in an appropriate  
19 manner, with the directives that came from the physicians.

20 DR. CASALINO: In the L.A. area.

21 DR. CROSSON: In the L.A. area. And the question  
22 has always been, you know, how replicable is that model to

1 situations with less population density, less hospitals,  
2 and the like.

3 DR. JAFFERY: Yeah. I guess one more thing to  
4 think about as we carry this conversation on, and I said  
5 this a little bit, but, you know, again, it goes back to  
6 what exactly is success here? You know, we keep hearing  
7 people say that we haven't got much savings, and I'm not  
8 sure what the goal is. So where -- if 1 or 2 percent isn't  
9 success here, then what is? Is it 5 percent? Is it 10  
10 percent? I mean, I think that would be good to understand.

11 And I think the other thing is, you know, we talk  
12 in other spheres about, you know, trying to keep payments  
13 to efficient providers, and we don't really have a parallel  
14 situation here. You know, I think theoretically we want  
15 quality to continue to improve. Theoretically, I don't  
16 think we're talking about total cost of care going down to  
17 zero. And so what is -- is there some point where we get  
18 to a total cost of care for an average beneficiary in a  
19 geography that is the right amount and we're trying to keep  
20 costs from not going up higher than inflation, or are we  
21 always talking about trying to keep it going down? And it  
22 doesn't matter what we get to, that doesn't seem like a

1 sustainable approach.

2           So those may be some other things that we want to  
3 grapple with, so we actually understand if and when we get  
4 to success.

5           DR. CROSSON: David.

6           DR. GRABOWSKI: Just quickly on this idea of  
7 whether 1 or 2 percent is small or modest and whether we  
8 should celebrate that. I often after we get so few  
9 victories in health care policy, generally, Medicare policy  
10 specifically on this Commission, that we should celebrate  
11 any sort of savings we get with no corresponding decline in  
12 quality. So I think at times we can be very dismissive,  
13 and I think we should actually frame it as a real positive  
14 here, and I think you guys did that nicely during the  
15 presentation. There's no doubt we want to continue to  
16 innovative, but let's not lose sight of the fact that we've  
17 generated savings here.

18           DR. CROSSON: Okay. In summary, I think we had a  
19 very strong consensus here around the fact that we are  
20 generally in support of ACOs and ACO-like developments,  
21 moving towards prospectively taking responsibility for cost  
22 and quality of a population, without question. We have

1 been from the beginning. And that there are a host of large  
2 issues, program design issues, for example, with respect to  
3 ACOs or beyond ACOs, that we need to tackle. And again, I  
4 think this is consonant with where the Commission has been.

5           And so I think it was appropriate for people to  
6 reinforce that message, both to us and to anyone who is  
7 listening to us. And as I said, we're going to do that  
8 again in the spring.

9           Having said that, with respect to the issues on  
10 the table here -- and I'm going to test this, but I think  
11 that with the recognition that some Commissioners have  
12 remained silent on these choices, I get the general sense  
13 that moving to the NPI is something that -- I'm getting  
14 mostly bobble-head consensus here -- is something that we  
15 should do.

16           With respect to prospective versus retrospective  
17 assignment, I think -- my sense is that Dana moved the ball  
18 here on us, very effectively. And you said, Dana, in your  
19 comment, you know, there are some Commissioners around here  
20 who think retrospective assignment means you don't have  
21 anything until the year is over. I thought that, to be  
22 perfectly honest. And what you were describing as

1 concurrent, incorporated in my mind the notion that, well,  
2 in fact, yeah. I mean, there are mechanisms in place here  
3 for ACOs with retrospective assignment to have no immediate  
4 knowledge but relatively useful knowledge about who they  
5 were accountable for.

6 I think that's made this choice for the  
7 Commission rather difficult, because I think we have a  
8 consensus that yes, it's a good idea, it's a rational idea  
9 for an entity that's accountable for a population to know  
10 what that population is. Less clarity about whether that  
11 needs to be day one or whether that knowledge three months  
12 later is adequate to fulfill that same need.

13 And so I have not heard a consensus here. I've  
14 not heard a consensus here, that I can articulate, that  
15 says we should clearly favor prospective in the current way  
16 that it's organized, prospective versus retrospective,  
17 without complicating it. There's another issue, I think,  
18 that we have addressed directly with CMS, which is whether  
19 it makes sense for a particular ACO to change models from  
20 year to year, which is a secondary question, which I have  
21 some trouble understanding the rationale for.

22 But having said that, I want to test this with



1 you, because we do need to give direction to the staff. Do  
2 people feel strongly in favor of prospective assignment or  
3 retrospective assignment, or us remaining essentially  
4 agnostic on it at this point in time?

5 DR. SAFRAN: Jay, can I clarify a point?

6 DR. CROSSON: Yeah, I think Bruce put up his hand  
7 first.

8 DR. SAFRAN: I was just going to make one  
9 clarifying point, because I want folks to understand that  
10 with concurrent or retrospective, however we're going to  
11 label it, a provider who's in an ACO still on January 1st  
12 gets a list of the patients who are attributed to them, and  
13 then they get periodic -- in our case it was monthly; it  
14 sounds like CMS has been doing quarterly -- updates to  
15 whether that is shifting over time. So --

16 DR. CROSSON: But that's different from the  
17 payment mechanism.

18 DR. SAFRAN: Yes, it is. I just am saying that  
19 because you said, you know, in three months, and I wanted  
20 folks to understand like on January 1st --

21 DR. CROSSON: All right. I'm sorry.

22 DR. SAFRAN: On January 1st, you know who your

1 patients are, and then you periodically get updates if  
2 that's evolving.

3 DR. CROSSON: That's helpful. But the payment  
4 mechanism as opposed to the clarity around who you're  
5 responsible for is the different element. Right? Then  
6 help me because maybe I'm confusing myself as well as the  
7 Commission. What's the essential difference between the  
8 two approaches in your mind?

9 DR. SAFRAN: I don't know how the payment works  
10 in prospective, so I can only comment on the concurrent,  
11 which is that you're paid over the course of the year for  
12 the population that is attributed to you, and then at the  
13 end of the year, there's a settle-up on, you know, any  
14 difference between who you've been paid for and who  
15 actually manifests as your population.

16 DR. CROSSON: Okay. So we're throwing a curve  
17 ball in here.

18 PARTICIPANT: Can I ask Dana a question about  
19 that?

20 DR. CROSSON: Can anybody help? Kathy?

21 MS. BUTO: So if the primary care physician is in  
22 one ACO and the beneficiary in your example has a condition

1 that's best treated at another -- a hospital that's  
2 associated with another ACO, you know, medical expenses are  
3 in both ACOs, if you will. I liked your example of the  
4 expensive care is still accountable under the second ACO.  
5 It doesn't disappear and the first ACO has very little  
6 leverage. But how are the costs attributed to the two  
7 ACOs? Is it where the preponderance --

8 DR. SAFRAN: Right.

9 MS. BUTO: -- of cost is? Is that ACO  
10 responsible? Or how does that work?

11 DR. SAFRAN: We may be getting out of the level  
12 detail that I know, that I can remember clearly enough, and  
13 I should, you know, connect staff with the appropriate  
14 colleagues of mine from Blue Cross to describe this. My  
15 recollection of it is that the costs get assigned at the  
16 end of the year and, you know, settled up as to where care  
17 actually manifests. But, of course, over the -- like so  
18 the hospital that provided the care will get paid their  
19 fee-for-service rates, but who's accountable for that  
20 expense is the piece that I'm saying is moving. I hope  
21 that clarifies things.

22 DR. CROSSON: So Larry and then Amol.

1 DR. CASALINO: I thought I understood all this  
2 very well, and I thought that the staff did a great job of  
3 explaining things. But it seems pretty clear right now  
4 that -- it seems pretty clear to me that I don't have the  
5 understanding that I thought I had of either the AQC or  
6 what the Medicare ACO programs do. And I'm pretty sure  
7 that's true of some other Commissioners as well, which is a  
8 surprise.

9 I don't think we're going to resolve it with this  
10 kind of discussion now, so I would ask for the next time --  
11 I thought the staff did a great job, but it seems like we  
12 really need a kind of step-by-step-by step, and maybe for  
13 the AQC as well, if Dana's willing to provide that, step by  
14 step how the retrospective versus concurrent, if they're  
15 different, versus prospective attribution works not only in  
16 the current year, but then what happens -- if you start  
17 with year one, you know, what happens? You know, how does  
18 the benchmark get set? And how does that carry forward  
19 into future years? That's another kind of complication of  
20 this. I think we need it just kind of spoon-fed to us so  
21 we can have, frankly, a better informed discussion.

22 DR. CROSSON: Amol and then Bruce.

1 DR. NAVATHE: So I agree. I was going to try to  
2 answer your questions, Jay, but I think actually I'll just  
3 hold off for the sake of time.

4 One point I will make that I think is important  
5 for us to recognize is when -- you know, in a retrospective  
6 model vis-a-vis a prospective model, when you have  
7 somebody, a beneficiary, on your list initially to start  
8 out the year, but at the end of the year they end up not on  
9 your list, or vice versa -- right? There could be somebody  
10 who wasn't on your list who ends up on your list. The  
11 disproportionate reason that happens is because of spending  
12 and utilization. And so it's particularly damaging in some  
13 sense to an ACO when those shifts happen. The majority of  
14 patients who stay continuously attributed, there's going to  
15 be a big chunk of them that don't have a lot of  
16 utilization. The people who shift around, they have a lot  
17 of utilization. That's why it's particularly challenging,  
18 and at least from sort of a behavioral and management  
19 perspective can be particularly challenging.

20 So I think it's worth just noting that, yes, you  
21 can get most of it right on day 1 and day 30 and day 90,  
22 but the shifts that happen are happening for particularly

1 important people that tend to have an outsized impact on  
2 your performance in the program.

3 DR. CROSSON: Right, okay. I mean, I think what  
4 -- and maybe that's to repeat again, but I think what  
5 shifted for me was the notion that one of the primary  
6 reasons that I heard articulated for prospective assignment  
7 was the rational argument that, of course, you want to know  
8 who it is you're accountable for. And I think that  
9 argument -- for me, that argument was weakened as a  
10 consequence of this discussion, which left -- now I'm  
11 talking just for myself, but I'm also trying to get a sense  
12 of where we are as a Commission, and I think where we are  
13 is we need more information about this. We need to  
14 understand the mechanics here and the trade-offs in more  
15 detail before we come to a conclusion.

16 DR. PAUL GINSBURG: Yeah, I was just going to say  
17 I think, you know, that in your previous model, knowing  
18 those who you're responsible for, it's going to make the  
19 most difference for the low utilizers. And I think what  
20 Amol is talking about is the critical thing in ACOs'  
21 success or failure, it's going to be how they deal and how  
22 the high utilizers are attributed. So in a sense, that

1 advantage of prospectivity may not be what it's cracked up  
2 to be. But, you know, I think what I'm concerned about is  
3 just differences between the data that determines the  
4 benchmark and the data that -- you know, the time period  
5 for the benchmark and the time period for the shared  
6 savings.

7 DR. CROSSON: So just to be clear, what I was  
8 hearing you say, if I'm right, was an argument for  
9 retrospective assignment?

10 DR. PAUL GINSBURG: No.

11 DR. NAVATHE: No. I was saying that the  
12 certainty of knowing that you're managing a certain  
13 population has benefits, because when you start out -- they  
14 start out on your list for the year, the benchmark is set  
15 based on that population. At the end of the year, the  
16 reconciliation's based on that same population.

17 DR. CROSSON: Right.

18 DR. NAVATHE: So you know with certainty,  
19 effectively. In the retrospective model, while it does  
20 have advantages -- there's definitely trade-offs, but while  
21 it does have advantages that you're attributed based on who  
22 actually saw you, at the end of the year the benchmark is

1 effectively set for the population who you saw during the  
2 year. Right? That's the advantage. The downside is that  
3 there can be shifts compared to who you thought you were  
4 taking care of, and those shifts happen disproportionately  
5 for people who spend a lot. And so when you reconcile your  
6 list of here's who I thought I was for, who I was  
7 responsible for, and who did CMS reconcile me against as  
8 being responsible for, there's going to be a margin --  
9 there's going to be a group of patients who you didn't know  
10 and a group of patients who you thought you were  
11 responsible for who are no longer on your list. That group  
12 of patients, they have a lot of spending. And that's why  
13 it's particularly challenging for ACOs.

14 DR. CROSSON: Okay. Bruce and then Jonathan.  
15 Then I think we're going to have to stop.

16 MR. PYENSON: Yeah, just I agree with Amol on a  
17 practical issue. Currently, ACOs get quarterly data feeds  
18 with a lag. So the complexity of the lags on that also add  
19 a lot. You know, CMS claims after three months to be 95  
20 percent complete or more. But if you're getting quarterly  
21 feeds, there's an awful lot of lag by the time you get  
22 those, probably six weeks after the quarter completes, so



1 it's not a concurrent image.

2           There are, of course, alternatives. I think one  
3 of the Blues does monthly attribution, which sounds very  
4 much like fee-for-service. But I just wanted to add --

5           DR. CROSSON: But what you're describing with  
6 respect to the lag and the accuracy of that could be very  
7 different from what Dana experienced in Massachusetts in a  
8 much smaller environment.

9           MR. PYENSON: I suspect CMS was faster than Blue  
10 Cross Blue Shield of Massachusetts on processing.

11           DR. CROSSON: Okay.

12           MR. PYENSON: But I could be wrong.

13           DR. CROSSON: Well, I think we're going to have  
14 to let you guys work that out after the meeting.

15           [Laughter.]

16           DR. CROSSON: Jonathan.

17           DR. JAFFERY: Now I'll be very brief, and I know  
18 we're a little over time. To me, putting the conversation  
19 together, I think we can come up with some things where  
20 there are trade-offs and pros and cons to each of the  
21 retrospective, but I like calling it "concurrent," versus  
22 prospective. And my understanding of the policy

1 recommendation here is not so much whether we're deciding  
2 which is better for the ACO in some ways because at this  
3 point people can choose in some of these models, and what  
4 you're trying to say is let's make these all mandatory  
5 prospective, but, rather, is there gaming that occurs in  
6 one versus the other?

7           And so I think that's a little bit different than  
8 saying, well, what are the trade-offs? Because if there  
9 aren't -- if we're not concerned -- if the gaming question  
10 is off the table and there are trade-offs, then, you know,  
11 we should be able to leave it up to ACOs to decide which  
12 one they -- so that to me would be the question to resolve.

13           DR. CROSSON: And there could be ways to mitigate  
14 the potential for gaming. Okay. So, again, in summary,  
15 thanks for the work, emphasizing the importance of this and  
16 our future work. We're going to head towards NPI, come  
17 back with a recommendation there, and we need to do more  
18 work on the prospective versus retrospective, as well as  
19 alternatives, I think, you know, clarifying what's the  
20 problem we're trying to solve and whether there are  
21 alternatives that could be added to, for example, the  
22 retrospective assignment.

1           Okay. David, Luis, Jeff, thanks very much.

2           We now have time for a public discussion period.

3 If we have anyone in our audience who wishes to make a  
4 public comment, please come up to the microphone. I'll  
5 make a comment in a minute. This is an opportunity to  
6 address the Commission on issues that we have discussed  
7 this morning. We'd ask you to identify yourself by name  
8 and any organization that you are affiliated with, and  
9 please keep your comments to two minutes. When this light  
10 comes back on, that two minutes will have expired.

11           MS. TESTONI: Good morning. My name is Maureen  
12 Testoni. I am president and CEO of 340B Health. We're a  
13 trade association that represents over 1,400 hospitals that  
14 participate in the 340B program.

15           340B is vital for the safety net providers and  
16 for the patients that they serve, and I wanted to comment  
17 that we appreciate MedPAC's very thoughtful analysis that  
18 was presented today on 340B and on Medicare spending and  
19 beneficiary costs. We're really pleased to see how MedPAC  
20 really engaged and did a rigorous analysis of this issue.  
21 As was noted, this was the first of its kind that I've  
22 seen, and we spend a lot of time looking for that kind of

1 thing. And it was just a much more rigorous analysis than  
2 we've seen in the past by GAO or others.

3           We note that some of the findings about there  
4 being some differences for two of the five cancers that  
5 were looked at, and much of the differences can be  
6 explained by beneficiary characteristics and facility  
7 characteristics, are similar to research that 340B Health  
8 has done as well, even though we use completely different  
9 approaches in terms of looking at this issue.

10           So I wanted to thank the Commission for doing  
11 that, and I also wanted to thank the staff. We've been  
12 working with MedPAC staff for a number of years, and we  
13 really appreciate how open they always are to meeting with  
14 all the stakeholders, looking at all of our research and  
15 data, and being open to different points of view.

16           Thank you.

17           DR. CROSSON: Thank you.

18           MR. ZAMAN: Good morning. My name is Shahid  
19 Zaman, and I'm with America's Essential Hospitals. I  
20 wanted to provide the association's perspective on the 340B  
21 discussion as well, and I echo Maureen's comments as well.  
22 We really appreciate the thorough look at the link between

1 the 340B program and any potential behavior with regard to  
2 the use of Part B drugs.

3           So we represent 300 hospitals, nearly all of  
4 which are 340B hospitals. Essential hospitals  
5 disproportionately care for low-income patients, so about  
6 75 percent of our patients are on Medicare or Medicaid or  
7 uninsured, and they face many social risk factors such as  
8 homelessness or food insecurity.

9           This commitment to mission means that the average  
10 essential hospital provides about \$70 million in  
11 uncompensated care costs, about 10 times the national  
12 average, and operates on narrow all-payer margins. So the  
13 average essential hospital operates on about a 1 to 1.5  
14 percent margin.

15           Given these challenges, 340B is a lifeline for  
16 our hospitals and their patients and helps our hospitals  
17 provide many comprehensive services to their patients.

18           So, again, we appreciate the research and would  
19 echo the point about 340B not being the underlying driver  
20 of high drug prices. Instead, it has been for our  
21 hospitals a key buffer for hospitals and patients from  
22 runaway prices. 340B discounts make up less than 2 percent

1 of annual drug sales, so it's inconceivable that such a  
2 small program could drive up increases.

3           The one undisputed factor driving up spending on  
4 drugs in both Medicare and in the larger health care system  
5 is rising list prices, which are set by manufacturers and  
6 not by hospitals.

7           As was alluded to in the discussion, 340B  
8 hospitals, there are distinctions in the characteristics of  
9 340B hospitals versus non-340B hospitals, and the  
10 Commission did allude to this in terms of patient  
11 characteristics and being academic medical centers that are  
12 important to take into account.

13           And just one quick point on the question that was  
14 asked about the 340B litigation. We are a party to that  
15 litigation, and I think a question was asked about whether  
16 it was about the -- or the legal issue was the  
17 redistribution or just whether CMS had the authority to  
18 make the cut. So the issue that the district court ruled  
19 on in favor of us was simply on whether CMS had authority  
20 to reduce payments for 340B hospitals.

21           Thank you.

22           DR. CROSSON: Seeing no further discussants, we

1 are adjourned until the March meeting. Thanks very much.

2 [Whereupon, at 11:44 a.m., the meeting was

3 adjourned.]

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